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# St. Bartholomew's Hospital



## JOURNAL.

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

VOL. XXXV.—No. 1.]

OCTOBER 1ST, 1927.

PRICE NINEPENCE.

### CALENDAR.

Sat.,	Oct.	1.—Rugby Match <i>v.</i> Old Millhillians. Hockey Club Trial Match.
Tues.,	"	4.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Fri.,	"	7.—Prof. Fraser and Prof. Gask on duty. Medicine. Clinical Lecture by Sir Thomas Horder.
Sat.,	"	8.—Rugby Match <i>v.</i> Richmond. Hockey Match <i>v.</i> Guy's. Home.
Mon.,	"	10.—Special Subject Lecture by Mr. Elmslie.
Tues.,	"	11.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Wed.,	"	12.—Surgery. Clinical Lecture by Sir Holburt Waring. Rugby Match <i>v.</i> Cardiff.
Fri.,	"	14.—Sir Percival Hartley and Mr. McAdam Eccles on duty. Medicine. Clinical Lecture by Dr. Morley Fletcher.
Sat.,	"	15.—Rugby Match <i>v.</i> R.M.A. (Woolwich). Hockey Match <i>v.</i> Beckenham II. Home.
Mon.,	"	17.—Special Subject Lecture by Mr. Harmer.
Tues.,	"	18.—Sir Thomas Horder and Mr. L. B. Rawling on duty.
Wed.,	"	19.—Surgery. Clinical Lecture by Sir Holburt Waring. Rugby Match <i>v.</i> Cambridge University.
Fri.,	"	21.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty. Medicine. Clinical Lecture by Sir Thomas Horder.
Sat.,	"	22.— <b>Last day for receiving matter for the November issue of the Journal.</b> Rugby Match <i>v.</i> U. S. (Chatham). Hockey Match <i>v.</i> Woolwich Garrison. Away.
Mon.,	"	24.—Special Subject Lecture by Mr. Just.
Tues.,	"	25.—Prof. Fraser and Prof. Gask on duty.
Wed.,	"	26.—Surgery. Clinical Lecture by Mr. McAdam Eccles.
Thurs.,	"	27.— <b>Abernethian Society.—Inaugural Address at 8.30: Sir D'Arcy Power, K.B.E., "Books by St. Bartholomew's Men."</b>
Fri.,	"	28.—Dr. Morley Fletcher and Sir Holburt Waring on duty. Medicine. Clinical Lecture by Dr. Langdon Brown.
Sat.,	"	29.—Rugby Match <i>v.</i> Old Leysians. Hockey Match <i>v.</i> Clare College, Cambridge. Home.
Mon.,	"	31.—Special Subject Lecture by Mr. Harmer.

### EDITORIAL.

**T**HE main function of the October number of a hospital journal is to welcome very warmly those as yet dim shades and unknown faces which are at this season materializing from the chaos of other schools and universities, into forms whose shapes will before long become familiar to every eye and whose names may in time ring in every ear. This process of materialization, in some cases meteoric, is in others only demonstrated by a succession of little notorieties. One will habitually hand out chromicized catgut on a curved needle instead of No. 2 silk on a reel; one will take his place proudly among the elect at surgical consultations or at lunch by the round table of the Chief Assistants; another will choose the sacred hour of noon for his hurried visits to the wards. These are all trivial affairs which usually loom large only in the frightened cortex of their committer. He alone does not know that we have all done one or other of these things and that the memory of them dies early. Placed in the whirl of the Accident Box after the eternal calm of a Dissecting Room, the most philosophic scientist will forget that every one of those celestial figures to whom he flies for aid has (not so long ago) been in a precisely similar condition of hopeless vacuity, and he will, before his first three months are over, restrain the universal impulse to emulate Edgar Wallace and dress his sensations up in breathless narrative. He will then be able to sit quite quietly, and reflect that herein there is to be found by all an infinite sense of freedom and responsibility, which adds years to a man's age and inches to his prestige among the laity and his family. Further, when he comes to learn more of those other hospitals that he might so nearly have gone to will he realize that in St. Bartholomew's is the only place for him to be.

To all new members of the Hospital we would here

make it plain that we are very glad to have you; that we hope you will get from her more than everything you came for; and that in return you will help a little to raise her high prestige, and with hers that of the Ancient Art of Medicine.

In welcoming the new we must say good-bye to at least one old friend—the last remains of Christ's Hospital, whose skeleton already stood almost disarticulated on St. Matthew's Day. We offer our cordial sympathy to those Old Blues whose memories—so ably described by their spokesman in the *Times* recently—will be deprived of their ancient playground. It is a comfort to feel that they are superseded by something as vital to the neighbourhood as a surgical block, and not by the inevitable garage or picture-house.

The recent deputation to Mr. Neville Chamberlain by the People's League of Health, one of whose objects was to stress the need for instituting periodical medical examination for all persons benefiting under the National Insurance Acts, struck a great blow for that popular slogan, "Preventive Medicine." While to our thinking this phrase is waste of time when applied by the anti-cancer lay-writer to the preaching of a new life—a wineless, tobaccoless life of cold baths, strict régime and rabbit food (what full-blooded healthy Englishman will be threatened into asceticism?)—yet the deputation's argument "that the absence of early treatment of pathological conditions was the common factor in maintaining the incidence of disease in the country" is obviously a most important one. It is sad that the probable cost is as yet too great for these periodical examinations to become a working proposition.

In the light of all this it is very interesting to receive a paper by Irving Fisher, Professor of Economics of Yale University, on the "Lengthening of Human Life," in which the subject is again discussed, this time from the point of view of obliterating the "preventable diseases," with the idea of increased and universal longevity. Thus he says, "the mortality among graduates of women's colleges where medical inspection, supervision and instruction have been used is less than one-third that of the general population, showing that the ordinary mortality of youth is two-thirds preventable." The whole L.C.C. system for children is based on this.

This gives us one ambition to live up to, and another is pointed out by Prof. Fisher when he comes to discuss our subject of periodical medical examinations: "To merely examine a man is not enough; the physician must have something educational to give . . . ; the essence of improving health for the so-called well is improving habits."

In summing up the biological evidences in favour of a possibility of an increased life-span, which includes Woodruff's work in culturing *Paramacium* to 8500 generations without a death, and the well-known experiment in which Carrel kept alive the cells of a chicken embryo's heart for many years by washing out the products of katabolism and protecting against infection and food deficiency, it is possible to conclude that a man, like a watch, has no normal life-span. "It is all a matter of having the man or the watch well-built to start with, and well taken care of afterwards." In other words, go for eugenics and periodical medical scrutiny. Don't wait till an abscess forms; have your teeth looked at, and avoid nougat.

The Merchant Taylors' Company, who were among the Hospital's earliest acquaintances in the City, have agreed to contribute £7000 to the Reconstruction Fund, paying £1000 for the next seven years.

E. Miles Atkinson was elected a Hunterian Professor for the ensuing year.—*Lancet*, July 23rd, 1927.

Sir James Berry received the degree of D.C.L. *Honoris Causa* at a Convocation held in the University of Durham June 28th.—*Lancet*, July 9th, 1927.

Dr. Canti's film has now achieved an International reputation. Following on its enthusiastic reception by the British Medical Association in the Operetta House in Edinburgh in July, it was shown on three occasions in Buda Pest at the Tenth International Zoological Conference in September. It was exhibited first of all in the Koranyi Clinic in the Cytological Section, who declared it worthy of presentation to the whole Conference. Two days later it was presented on a big scale in the Urania Cinema House, the Prime Minister and the Minister of Education attending. This Cinema House is one built exclusively for the presentation of scientific films and is very finely fitted out for the purpose. It is said that in England such an undertaking would probably be a complete failure. This film dealt only with the spade-work of the filming of tissue culture; it leads the way to future work of a most interesting nature, and Dr. Canti has promised to give us the benefit of an early view of his next film—perhaps next spring.

**We were generous enough to offer last month a prize of one guinea** to encourage in the Hospital the timid plant of Literary Composition; but the sickly seedling will not apparently grow even in the special nutrient soil provided. Not even the hope of earthly gain (and consider how much beer one may consume for

a guinea) has dragged out anything really worth publishing. All right, we don't care; we did very well with the money. But in order not to appear close-fisted we have been prevailed on to repeat the offer this month, giving as alternate subjects, "**What a Freshman thinks of the Hospital,**" and "**What the Hospital thinks of Freshmen.**" There now; easy money, and the uncommon satisfaction of possibly seeing yourself in print in one of Great Britain's leading monthlies.

The Editor receives many shocks, but perhaps none so unexpected as that he staggered under when he opened an innocent-looking letter, to find the following:

"DEAR SIR,—Perhaps I am unduly persistent in again inquiring as to the state of your rupture, since I wrote you two letters before this and have not received your order. But experience is a great teacher. It has taught me never to give up so long as I am reasonably certain I am writing to someone who is ruptured. Almost every day I succeed in drawing out someone who has nursed his misfortune so long and failed so often to cure it as to become thoroughly discouraged . . ." And so on, until we implored the Sub-Editor to tell us if there really was anything wrong which might have escaped our notice.

#### OBITUARIES.

SIR ARTHUR SHIPLEY, G.B.E., F.R.S.

Few people realized that Sir Arthur Shipley, Master of Christ's College, Cambridge, who died on September 22nd, started his career by entering the Hospital from University College School. But "at an early age," to quote the *Times*, "he decided to take at least the first part of his training at Cambridge, and accordingly entered at Christ's. There he turned definitely to Zoology under Balfour and Sedgwick, who were then making Cambridge a chief centre of zoological research and teaching in Europe." As author, lecturer, Master and Vice-Chancellor Sir Arthur's career was most brilliant; and to one who had the privilege of dining with him shortly before his last illness, his knowledge of international affairs and his delightful humour as a raconteur seemed as lively as ever. His death will be much regretted on both sides of the Atlantic.

NORMAN DOWLING, M.R.C.S., L.R.C.P.

Dr. Norman Dowling, who died on August 11th, 1927, was a great personality in Melbourne. Born in 1865, in that city, he was educated at Sydney Grammar School before going to London, where he qualified at St. Bartholomew's, returning to Australia upon leaving. A cutting from the *Melbourne Chronicle* bears witness to his popularity and good works.

#### A WELCOME.

AND SOME WORDS OF ADVICE TO THOSE ENTERING THE COLLEGE AND THE HOSPITAL.

THE Editor of the JOURNAL will, I am sure, excuse me if I usurp his privilege by voicing the hearty welcome which all present and old St. Bartholomew's men offer to those who have joined us at the beginning of this Session. Some are at the commencement of their professional training, others have already spent some years in the study of the pre-clinical subjects, and we welcome all to St. Bartholomew's Hospital and to the Medical College. All are on the threshold of the Medical Profession, on the threshold of a great undertaking, and must feel a little that there is something unknown, something, perhaps, mysterious ahead. It is a great calling and a life of great achievements that lie ahead, and here at the Hospital and College we endeavour to help you to see more clearly what it is that lies in front, and we endeavour to prepare you and equip you.

It is doubtful if you realize how greatly you are to be congratulated on your choice of a profession. In spite of the innumerable varieties of temperament and of training that are to be found among you, the profession of medicine offers opportunities for each one. You may love to study your fellow men, or hope to devote your life and energies to the relief of suffering; no better opportunities could be found than those that accompany the practice of medicine. You may be of a severely logical habit of mind, or intolerant of compromise: the laboratories are open to you. You may have the ambitions and yearnings of the discoverer: medical science is in its infancy and vast fields await you. If you wish to be a medical missionary there are many posts to be filled. If the life in a Government Service attracts you, the Army, the Navy and the Colonial Service will want you. If you have gifts for administration, a post as medical officer of health or under the Board of Education will enable you to use your talents. You can live in a city or in a quiet country-side, and you may choose the climate that suits you. Everyone has ambitions, but if you are overwhelmingly ambitious there are mountain peaks that few can climb.

Whatever you are or whatever you wish to be, the profession of medicine has a niche for you, unless—and this is the only exception I can think of—unless you are selfish. Perhaps you will think I should have said, "unless you can pass the examinations." But you have passed various entrance examinations already,

and therefore you are all quite capable of passing the others. And when in due course you are registered as being duly qualified to practise, you can always at the very least earn a living.

The whole or part of the curriculum still lies before you. Many educationalists of experience and reputation have helped to design that curriculum, and every detail in it has been the subject of prolonged and sometimes bitter argument. If you have studied it at all critically, you may well be excused if you wonder what principle guided those who arranged it. When you have been through it the principle will be clear to you, but it may be helpful to know now something of what you are expected to do in the next few years, and to see how each subject and each year's work is dependent on what has come before, and how no single part of the curriculum can be separated from the rest and no part really left behind and forgotten. It would be far better in theory if the subjects could be taken concurrently, or at least overlap to a greater extent than they do, but there are obvious practical difficulties, and if at times you find something to criticize, remember that those who are responsible for the curriculum find more to criticize than you do, but remember also that they are humbly desirous of receiving your considered opinions on the matter. Those who have already spent some years here, and who are entering now upon the period of clinical studies, may find something of interest and something helpful and perhaps something comforting in reviewing what it is that they have successfully accomplished, and in viewing what lies before them.

#### THE PRE-CLINICAL STUDIES.

A knowledge of the more simple and essential properties of inorganic bodies has already been acquired in courses in chemistry and physics by those now commencing their pre-clinical years. In most instances a beginning has been made towards an appreciation of the difference between inorganic material and living matter. Throughout your lives you will gain a better and better appreciation of this difference. The study of the structure of plants, and of the functions of the various parts of a plant, introduces you to new conceptions, but the functioning of the whole plant, the co-ordination of the various parts into a whole that can maintain life successfully in spite of the ever changing environmental conditions and the onslaughts of innumerable living rivals is a subject that is understood but imperfectly, even by biologists. As organic chemistry, bio-chemistry and bio-physics are further elucidated, so knowledge of the manner in which a plant reacts to environmental changes is slowly increasing.

On turning to animal life a vastly more complicated situation is found. The animal is less limited in the field of its activities, and so is exposed to a far greater variety of conditions and a far greater variety of dangers. For life to be maintained there must be mechanisms for meeting the ever-changing conditions and the ever-present dangers. Among the more highly-developed animals, volition enters into the factors that increase the variability in the conditions of life, and the more highly developed the animal the more is this so, and the more difficult it becomes to recognize the environmental factor responsible for some change in the structure or some altered functioning in the living unit.

In the profession of medicine the subject of study is the most highly developed of all animals with a capacity for volition that has not yet been gauged. In anatomy the structure of the human body is examined, and the meaning of structure in relation to function. The functioning of the whole and the functions of the various organs and systems of organs are observed and examined in the course in physiology. It is obvious that as knowledge of chemistry, physics and biology is increasing daily, if all too slowly, so the science of human physiology must be slowly developing. If explanations of all observed facts are to be given, most of them must be of a hypothetical nature, and so subject to alteration or even to absolute contradiction as new knowledge is acquired. As the science of physiology evolves, the understanding of the significance of structure must evolve also. The anatomy and physiology that you acquire in your curriculum is the orthodox knowledge of the day. Knowledge is but slowly gained, but if you appreciate the advances of the last few decades you will appreciate the rate of change. Knowledge grows sufficiently rapidly to materially alter the practice of medicine in the lifetime of a human being, sometimes in a space of time measured by months. A medical man is thus living and working in a field of ever-changing knowledge, a field that is ever expanding, while details are ever becoming clearer and more distinctly defined. He is part of the field, perhaps the most essential part, and there is no limit to the extent of expansion or the clearness of definition beyond which the field, with him and his successors as essential parts of it, will not surely pass.

#### THE CLINICAL YEARS.

It is only when the structure of the human body and its modes of functioning to maintain life and health in the manifold situations that are met with in ordinary existence are understood that the study of diseased persons can be entered upon intelligently. Pathology deals with the types of disease processes that affect the

human body and of the reactions of the body to them. It deals in generalizations, just as anatomy and physiology do, but in the Department of Pathology you will also see numerous examples of the effects of disease in individuals, and so learn how variable are the manifestations of disease, and how difficult it is to foresee the effect of applying general principles to particular instances; but it is from the study of numerous examples that generalizations are formulated.

The methods used in the examination of patients must be accurately and minutely mastered, but before the sick person can be approached intelligently the results of the applications of these methods to the healthy must be observed and appreciated. Now comes the most trying period in the curriculum. You are face to face with the individual patient. All the knowledge that you have acquired of the principles of the structure and functioning of the human body in health and disease, and of the disease processes that affect it, is of little use unless you realize that one individual differs from another to such an extent as to alter materially the apparent signs and symptoms of disease. The disease may be the same, but the person is different, and so no two patients ever present the same picture of the disease. Every patient must be a separate and an original study, and in the study of the person there is no organized science to help you and very little exact knowledge to be handed on to you. Psychology is slowly developing, but is not ready for you, and common sense, intuition and experience are the instruments to be used in the investigation, and are essential tools both for diagnosis and efficient treatment. In some patients the disturbance to health is due so much to temperamental and psychic factors that the medical sciences to which you have devoted so many years of study seem of little use; in others the disease process and the reactions of the body to it are so obvious and so localized that there is a temptation to forget the patient with his complicated mentality, his inhibitions and veiled reactions. Not only must each patient be carefully studied, but each person must be skilfully and gently handled. Treat each patient as if she or he were your own mother or father, your own daughter or son. You will lose nothing and gain much; to the patient the gain will be incalculable. Patients have eyes and ears, and if they say little they often understand more than you appreciate, and they ponder greatly on what they see and hear.

In the hospital the patients are segregated in wards and departments according to the nature and location of the disease process requiring treatment. This is in some respects an unfortunate arrangement. The hospital is staffed by a team of highly skilled experts, who

have devoted their time mainly to one part of professional work. By so doing they have become highly expert and are able to advance knowledge. In this way the patients obtain the benefit of the best skill available, and that this skill may be used to the greatest advantage it is necessary to form special departments, and to admit each patient according to his needs to one or other of these departments. There is a possibility that the general condition of a patient and his personality may be overlooked in a department staffed by men all highly skilled in one direction, but it is small. The greater danger is that you may obtain the impression that in the presence of some outstanding and localized disturbance the general state of the patient can be ignored. There is always, however, a medical practitioner in the background, who has studied his patient and who is supervising the management of the case. The treatment in hospital is really but an incident in this management, though an incident of great importance requiring the skill of an expert. If you will remember this, there will be no danger in learning your life's work under the guidance of a number of highly specialized men, and the more expert they are the more you will gain.

The three years of clinical study cannot provide you with replicas of the cases you are to meet with in the years to come, nor with an accurate set of rules for the diagnosis and treatment of individual cases, but they can equip you with general principles and examples so that you may know how to approach every problem, what must be done to solve each problem, and how each and every patient can be managed so that the troubles and worries of ill-health may be shifted to as great an extent as possible from his shoulders to your own.

You have not, however, merely entered a medical school; you have become part of a community which is interested in you personally. You will make life-long and valuable friendships, not only among your contemporaries, but also among your seniors. It is your part in the community to keep the community alive and to give it enthusiasms and freshness. The various clubs look to you for help, and remember that you cannot work well if you work all the time, and that there is for each individual a relation between the time spent in work and the time spent in rest that is optional. The community intends to be proud of you, so let it fulfil its intention as easily as possible, and when in doubt, whether in matters of work or not, do not forget that we are each and all ready and anxious to give all the advice and help we can.

F. R. F.

## HEART DISEASE.



RECENT large work on *Facts Concerning Heart Disease* by Cabot in collaboration with other members of the staff attached to the clinics at Harvard University brings it home to one how even the positive findings in the dead-house, if not associated with the previous clinical histories, may be very misleading. Here follows a short summary of this work by Cabot.

## SUMMARY FROM CABOT: FACTS OF HEART.

Ninety per cent. genuine cases of heart disease are either "rheumatic," "syphilitic" or "hypertensive." Acute and subacute endocarditis generally due to streptococcal infection say 10%, but most of these are with other general infections like peritonitis, etc. Otherwise 5% represents the actual heart infections. Rheumatic hearts begin in early life and more often in females. When the aortic valve is also affected in rheumatic hearts, 25 out of 28 such cases were in males. Syphilitic heart disease begins usually between 35 and 45, and most often in the aortic area, but after 50 years the hypertensive heart cases arise. Heart disease in the young woman is usually mitral rheumatic, in middle-aged men it is generally syphilitic aortic, and the hypertensive is in those over 50, who have not had early signs of any heart disease. Roughly, rheumatism selects the mitral area, syphilis the aortic, and hypertensive disease enlarges the whole heart, but with no valvular disease. And hypertensive disease occupies the far greater number of cases of heart disease.

*Rheumatic.*—In more than half the cases the mitral valve alone, and never any other valve singly. But two, three or four valves may be affected in chronic disease; total 70 to 75 only mitral. If aortic was also diseased with mitral, then in 25 out of 28 cases it was in males. Palpitation or fibrillation is usually felt early in mitral cases and less so if other valves are affected beside mitral. More than half the mitrals do not die of passive congestion, but from some other intercurrent disease. More than half the cases of mitral disease are not diagnosed during life. Even a very small stenosed mitral does not necessarily make the case worse. Mitral regurgitation found only in 3 cases out of 1906, and is not diagnosable.

*Aortic stenosis.*—Only 28 cases out of 1906; chiefly in old men. Not much history of previous rheumatism. But they may be old cases of septic endocarditis that have got well, because in many cases old renal infarctions are found. Generally aortic regurgitation, but no diastolic murmur. Much hypertrophy of heart. Also high blood-pressure and very often associated renal disease.

It is most common in men, and sudden death is common. And most die of heart failure, *i. e.* passive congestion.

*Syphilitic heart disease* only attacks the aortic valve or the aorta. Is six times more common in men than women. May lie dormant fifteen or twenty years. But when diagnosed, then two years sees the end. Much hypertrophy if the aortic valve is affected, but no hypertrophy if the valve is normal. Aneurysm does not cause hypertrophy. Wassermann 80%. No other disease but syphilis causes aneurysm. Angina common.

*Hypertensive disease.*—Includes all cases where there were no valve lesions and no chronic pericarditis. Arterio-sclerosis does not cause hypertension. Nephritis may do so, but not always. In fact it is common without either of these conditions (nephritis or arterio-sclerosis). Generally high blood-pressure. One-third of the cases end in heart failure; but many die of other diseases. Twice as common in men. Hypertrophy of pernicious anemia and leukemia have high blood-pressure. Myocarditis is only a curiosity.

*Acute and subacute septic endocarditis.*—Some recover. Ages and valves affected most like those in rheumatism; equal sexes; young persons most. Nephritis 40%. Never gonococcus or influenza germs, nor hypertrophy or failing heart (passive congestion).

*Acute pericarditis.* Rare, 5% an ending to other disease. Diagnosis difficult.

*Chronic pericarditis.* Like acute, is overwhelmingly common in males. It leads to the greatest hypertrophy when there has been past mediastinitis with the pericarditis (adhesions). Only 6 out of 112 diagnosed. Various murmurs lead to mistakes.

*Thyrocardiac disease.*—Noisy and over-acting hearts. No constant lesion, the symptoms caused by the toxins.

*Angina pectoris and cardiac infarct.*—If distinguished from cardiac infarct, then no constant anatomical basis. The coronary arteries may be diseased or may not be affected.

Coronary occlusions, acute or chronic, with or without cardiac infarction, may be symptomless.

Cabot also states that the total number of cases with hypertensive hearts is greater than all the rheumatic hearts added to the syphilitic hearts.

## COMMENTS ON THIS SUMMARY.

After reading such a work as that written by Prof. Carey Coombs on rheumatic heart disease, it is indeed startling to read that *myocarditis* is a curiosity, and in fact unknown. But the compilers of Cabot's work can clearly have had no experience in the acute and chronic cases of rheumatic carditis as met with in this country during the first three decades of life. Again, in spite of their recognition of so much *hypertensive* heart

## ANNOTATIONS.

Contributions to this Column are invited.

## AN UNUSUAL CASE OF RUPTURE OF THE UTERUS.

On July 13th I was called by a district nurse to a Mrs. C.—on account of "unsatisfactory condition of patient and labour not progressing." The patient, a 7-para, at 36, stated that labour had commenced twelve hours before, though she had been very upset by a flash of lightning which struck down near her house on the morning of the previous day. When I saw her she was somewhat pale, temperature 99.4° (this rose to 100.2° half an hour later), a fairly good pulse of 120; she complained of pain only when lying on her left side. On examination the os was the size of half a crown, the uterus was quite hard and no retraction could be detected.

*Diagnosis.*—Concealed accidental haemorrhage with tonic uterine contraction. She was removed to hospital, 2½ miles away, as soon as possible and Caesarian section performed at once. I found that the uterus was distended with blood, and that there had been complete premature separation of placenta and membranes. The child, 9½ lb., was dead. About a pint and a half of blood-clot was removed from the peritoneal cavity, and on delivering the uterus for suturing, a 2-in. rent was found at the summit of the fundus, and also a rent into the right broad ligament, which was distended with blood, though there was no rupture of the peritoneum in this region. The upper rent and the uterine wound were closed in the usual manner and the right tube and ovary removed, and the peritoneum in this region only sewn over with catgut. The patient's condition would not allow of further interference, and as it was, the total duration of the operation was just under the half hour. There was nothing of importance in the convalescence. A month later, in order to avoid a similar catastrophe in the future, I tied the remaining tube, in spite of a chemist assuring the husband that such an operation was quite unnecessary, as he (the chemist) could sell him something which would act equally well.

The interesting points are, I think: (1) The unusually good general condition of the patient considering the severity of her local condition. (2) The rise of temperature in such severe haemorrhage. This must, I presume, be accounted for by the slowness of the haemorrhage and its partial control by the tonic uterine contraction, thus allowing some absorption of the blood serum. (3) The fact of there being two minor rents and not one large one. (4) The extraordinary interference by the chemist.

Early this year I was consulted by a lady of colour from the West Coast of Africa. She had two abscesses in the leg and one on the plantar surface of the big toe. There were also several nodules in the skin of the leg, and the condition was evidently due to the African jigger.

The abscesses were in the subcutaneous tissue and there was little obvious inflammation, though there was considerable undermined skin.

I opened the abscesses, and ulcers were left which showed no tendency to heal. Weeks went by and nothing I tried produced the desired effect. At the end of two or three months I installed a small ultra-violet apparatus and tried it on the ulcers. The effect was startling. After the first application of 15 minutes with carbon-tungsten arc at 18 in. the toes healed. Three further applications healed the leg ulcers in a fortnight.

Last Monday I wrote on Friday—a nurse consulted me for a large carbuncle occupying the whole of the chin, with seven or eight openings. On Tuesday I gave it 15 minutes' exposure to the carbon-tungsten arc at 12 in. The next day—Wednesday—I was astounded at the change; the swelling was less, the hard red swelling at the outer part was of a bluish colour and much softer. She told me that during the night there had been a large amount of discharge. I repeated the exposure and told her to report to-day. To-day all inflammation and swelling have gone; all the openings have healed except three, which are small granulating areas. I have given her another exposure which will evidently complete the cure.

If anyone had told me of such a rapid cure of a carbuncle I should not have believed it possible, but as I have seen it I can vouch for it. As I was one of Mr. Willett's house surgeons in 1889 I have passed the age of enthusiasm when the hoped for may be taken for fact.

disease (which in their experience outnumber all the rheumatic and syphilitic hearts added together), they do not grasp such a thing as chronic myocardial degeneration—the certain outcome and ending of all hypertrophied hearts.

Their statement that *mitral regurgitation* is an unknown disease in America must surely ignore all the early histories of probably every case of mitral stenosis.

Apart from these strange deductions, their experiences in other matters are most interesting. That fully a half of all rheumatic hearts die of other intercurrent endings rather than of passive congestions from failing heart muscles is worthy of note.

That so many cases of real heart disease escape diagnosis until post-mortem examination tallies with the records of our own hospitals in the matter of kidney diseases.

The first statement in their book is somewhat in line with a tendency in many recent works on heart disease in this country, namely, that when a patient elects to go to a medical man because he thinks he has a heart affection, then the medical man can assume positively without any examination that the patient has no actual heart disease, but is suffering from gastro-enteric disturbance of one kind or other.

This view about hearts is nearly as pernicious as the other view now prevalent, viz. that cardiac murmurs can almost be ignored as not being of any importance. However, in most things appertaining to medical treatment (in contra-distinction to surgical), the practice of the clinician of fifty years ago re-asserts itself as superior to most of the modern pretensions.

J. KINGSTON BARTON.

## BLEST ALKALOID!



SOME swear by salts of Kruschen, unpleasant potion, but—

Let nicotine inhibit, then stimulate your gut.

When the wife attacks your smoking, reply, "My dear, tu, tut;

This nicotine inhibits, then stimulates my gut."

From John o'Groats to Land's End in palaces and huts There's nicotine inhibiting and stimulating guts.

Absorbed enteric toxins put the golfer off his putt;

Let nicotine inhibit, then stimulate his gut.

When you've reached the stage of toying with oport and with nut,

Let nicotine inhibit, then stimulate the gut.

So fellows take your briars and fill with Navy Cut,

For nicotine inhibits, then stimulates the gut:

SPLENUNCULUS.

A. B—, at. 33, came to the hospital complaining of pain in the left groin from which he had suffered for four months with increasing severity. He also, more recently, had suffered from abdominal pain of a colicky nature, made worse by purgatives. For two weeks he had noticed his left testicle was hard, but not enlarged. He had syphilis when 23 and his Wassermann reaction was positive.

The man had a large visible and palpable swelling on the left side of the abdomen extending 3 in. above and 2 in. below the umbilicus; it was absolutely fixed, was hard and slightly nodular, and was resonant on percussion. The left testicle was about one and a half times the size of the right and was hard and somewhat nodular.

A left orchidectomy was performed, and a section of the testicle showed a teratoma with malignant changes.

In all cases of abdominal tumours or even abdominal or lumbar pain (this patient had been treated for two months for "lumbago") the testicles must be most carefully examined, not only as regards their size, but more particularly with regard to their consistency. The case quoted above demonstrates extremely well how easy it is to overlook the primary growth in a testicle when it is not complained of by the patient, and when the abdominal symptoms and signs greatly predominate.

The secondary deposits in the lumbar lymphatic glands in malignant disease of the testicle are nearly always much larger than the primary growth itself, and must always be remembered in the diagnosis of obscure abdominal swellings.

In this case the abdominal swelling diminished considerably in size under X-ray treatment with some lessening of the pain, but the patient died within six months with metastases in the lungs and elsewhere.

#### A CASE OF EMPYEMA WITH FOCAL NEPHRITIS.

L. F. G—, et. 30, male; commercial traveller. Admitted 13.3.27 to Brompton Hospital under Dr. F. H. Young.

*History of present condition.*—Quite well till one month ago, when he felt "seedy and run down" for eight days. No cough. Was sent to bed, where he went through a typical attack of lobar pneumonia, except that the temperature did not come down.

On the fifth day he saw Dr. Young, who on the eleventh day explored the chest and diagnosed early empyema, and did an air replacement of the fluid (200 c.c. air) on the sixteenth day. The fluid looked like a streptococcal one, though bacteriologically it contained organisms which gave the bile reaction of a pneumococcus (only four colonies grew).

*Past history.*—There was none of any illness which might have given rise to nephritis.

*Condition on admission.*—No symptoms except constipation and general weakness. Looked acutely ill with sallow complexion, moist skin. Temperature 101.4°, pulse 120, respirations 30. Pulse rapid, regular, poor volume, artery rather rigid.

The heart was displaced  $\frac{1}{2}$  in. to the left, but was apparently normal.

*Abdomen natural.* No tenderness in renal angles.

*Central nervous system.*—Reflexes normal, but there was incontinence of urine and faeces and some delirium at night.

*The lungs showed "red" crepitations over the upper part of the left lung and pleural friction below these.*

*Right lung.* Crepitations over middle zone and below this absent. Vocal fremitus and distant breath-sounds from fifth rib in the mid-axillary line. No egophony.

*Urine* was of normal appearance (not smoky), specific gravity 1.025, reaction acid, and was loaded with albumen. Microscopically it contained blood, many granular and a few epithelial casts.

Urinary output 49 oz. in 24 hours.

*Blood count.*—Red blood-cells, 3,540,000; white blood-cells, 16,400.

*Treatment and course.*—Though the empyema appeared too early for operation, especially as accumulation of pus was delayed by the previous air replacement, it was recommended on account of the renal condition.

15.3.27: Operation. Drainage by Mr. Roberts. Half a pint of turbid fluid evacuated after resection of 2 in. of tenth right rib in the scapular line. Wound closed in layers with drainage-tube.

*Pleural fluid.*—No organisms seen. Tubercle bacilli nil, culture sterile.

18.3.27: There had been no further incontinence. Sleep good. Tongue furred. Some diarrhoea present this morning. At noon for the first time there was visible blood in the urine.

Blood-pressure 178/105.  
19.3.27: There was incontinence of urine and faeces during the night. Nocturnal temperature 103.4°, pulse 128, respirations only 20.

There was a rash over trunk and upper extremities which consisted of large discrete papules. There was some oedema of the ankles and slight puffiness under the eyes. Tongue raw, gums not bleeding, no dyspnoea, no nausea.

21.3.27: Blood-culture sterile. Blood-urea 137 mgrm. per 100 c.c.  
*Diet.*—Arrowroot, jellies, one slice of bread and butter, fluids to 10 oz a day.

24.3.27: Blood-pressure 150/97. Stitches and tube removed; wound edges not inflamed.

28.3.27: Cavity wash-out with dilute eusol. On "blow-bottles." Frequency of micturition at this time was 3 times daily, 4 times nightly.

31.3.27: Blood-urea 155 mgrm. per 100 c.c. Urine no visible blood. Albumen a trace.

1.4.27: Urine contains very numerous granular casts, some hyaline and a few epithelial casts. A few red blood-cells present.

12.4.27: Blood-pressure 150/98.

13.4.27: No nocturnal micturition for the first time last night. Blood-urea 62 mgrm. per 100 c.c.

22.4.27: Wound closing down; wash-out practically clear. Patient up one hour on couch.

30.4.27: Patient up three hours.

5.5.27: X-ray shows complete re-expansion of lung.

6.5.27: Blood-urea 13 mgrm. per 100 c.c. Urine clear, no albumen.

7.5.27: Patient discharged; home.

Since then has been at work and perfectly well. Throughout the patient had no symptoms during the day and was ravenously hungry on his low protein diet.

This case is published in full to show the exact stages in treatment, which, though conservative, led to a remarkably quick recovery. On March 19th he looked thoroughly uræmic, with a blood-urea of 137 mgrm. per 100 c.c., and even a month later his blood-urea was 62 mgrm. per 100 c.c. Yet a month after that he was at work and has remained well, though a six months' prognosis is usually given for patients with a blood-urea of over 100.

Early gas replacement of empyemata is usually to be deprecated, as it prevents the localization of the pus by organization; here, however, it very probably assisted materially in minimizing the intoxication.

That the fluid grew a pneumococcus, not a streptococcus, was rather surprising. Another abnormal factor which appeared to point to previous renal trouble (as opposed to a focal nephritis) was the raised blood-pressure.

#### A CASE OF POLYSEROSITIS TREATED BY OXYGEN REPLACEMENT.

E. T—, female, at. 50. Admitted 17.1.27 to Brompton Hospital from the Elizabeth Garrett Anderson Hospital.

*History of present condition.*—May, 1926, seized with acute sub-internal pain with shortness of breath. Felt feverish. Sent in to Elizabeth Garrett Anderson Hospital. Oedema of feet and legs found.

Laparotomy; ? indication.

July, 1926, patient was told she had pericarditis and was explored twice. 1½ oz. fluid removed. T.B. +.

August, 1926, abdomen began to swell.

*Past history.*—Nil of note. No family history of pulmonary tuberculosis.

*Symptoms.*—Slight cough, dyspnoea +, weakness +, occasional diarrhoea.

*Physical signs.*—Usual signs of extensive effusions into four serous cavities.

X-ray (19.1.27).—"Diaphragm obscured. Pericardial effusion. Pleural effusion both sides."

*Wassermann reaction* negative.

*Urine,* specific gravity 1.026; acid. Amorphous urates +; albumen a trace. Urea concentration test: No. 1, 3.30%; No. 2, 3.07%; No. 3, 2.90%.

25.1.27: Pericardiocentesis. ½ oz. thick yellowish fluid removed. A few c.c. of oxygen introduced with Clive Rivière needle and artificial pneumothorax apparatus under novocain. Stopped because of pain.

*Fluid.*—Tubercle bacilli nil, sterile. Cells mostly small mononuclear with occasional polymorph.

X-ray immediately after. Pericardial fluid appears less. Right chest no fluid seen now. Left chest partial pneumothorax. Trace of fluid at base. Both sides of diaphragm appear to be raised (? increase in abdominal pressure).

7.11.27: *Physical signs.*—See chart. Abdominal girth 32 in.

15.2.27: Flatulence; pain after food. Girth 34 in.

24.2.27: Pain and swelling neck, left arm. Veins dilated round left clavicle, oedema. Treated by antiphlogistine this improved.

Girth 37 in.

3.3.27: Paracentesis abdominis, 53 oz.; fluid yellow, clear. Fluid contained mononuclears. Tubercle bacilli nil, sterile.

4.3.27: Girth 35 in.

30.3.27: Paracentesis abdominis, 100 oz. fluid, rather thicker than before. Again small mononuclears. Tubercle bacilli nil, sterile.

8.4.27: *Left chest.*—Percussion note dull all over left side. Bronchial breathing by angle of left scapula.

*Oxygen replacement of left pleural sac.*—24 oz. thick yellow fluid removed. 200 c.c. oxygen put in. Final pressure + 2.0.

*Fluid.*—Tubercle bacilli nil, sterile. Mononuclears.

20.4.27: Abdominal girth 36 in. Some abdominal discomfort.

*Physical signs.*—Lungs. Left—Fluid dullness to seventh rib in scapular line.

Right—Only small amount of fluid at base.

*Pericardium.*—Fluid dullness up to second rib and increased to left. Right limit, midline.

7.5.27: Girth 34 in. Fluid not increasing in abdomen. Thickened omentum felt.

15.6.27: X-ray.—Right side of chest free from fluid. Lower half of left chest uniformly opaque.

18.6.27: Abdominal girth 32 in.

Abdomen not markedly distended. Dullness over both flanks extending to semilunar lines.

*Paracentesis.*—Midline no fluid. Right iliac region 12 oz. rather thick fluid, pathologically the same as before.

*Oxygen replacement with Clive Rivière (first) needle and artificial pneumothorax apparatus.* Initial pressure + 3, and had to be raised to + 10 before oxygen went in. 900 c.c. oxygen put in.

Wound strapped tightly with cotton wool pad as air tended to escape.

*Physical signs.*—Percussion note resonant over right flank and over rest of abdomen except for 1 in. in left flank. Lower border of liver one finger's breadth below costal margin. Patient well. Pulse-rate not increased.

4.7.27: Temperature settling, patient comfortable.

5.7.27: Temperature normal for first time since admission.

4.7.27: Temperature rising again. As patient was shortly to be transferred back to the Elizabeth Garrett Anderson Hospital, and at her own request, the oxygen replacement was repeated.

4.7.27: Girth 33 in. Paracentesis abdominis. Left flank only a small amount of flaky fluid obtained. 900 c.c. oxygen put in. Patient comfortable. Pulse 90, regular. No symptoms.

3.7.27: Patient transferred to Elizabeth Garrett Anderson Extension. Soon after admission a letter was received from them stating that the patient's condition was much improved and asking for details of the treatment, which the patient was anxious to continue.

In this case, of course, the ultimate prognosis seemed quite hopeless; treatment was therefore purely symptomatic. The patient, having been a year in bed, found it difficult to find a comfortable position until the effusions had been tapped. Further the removal of fluid enabled her to lie out of doors on a couch. The fluids kept on recurring until oxygen replaced.

The pericardial oxygen replacement was hardly a success. The needle could be felt against the heart-wall. There was surprisingly little room considering the apparent size of the effusion.

Intra-peritoneal oxygen has been to some extent used to map out the liver in ascitic effusions which tended to mask the lower border. In the present case this was also useful. Amyloid disease had been thought to be present at one time (albuminuria and diarrhoea), but although the liver was felt enlarged, its lower border was not accurately determined until the oxygen showed it up. It will be noted that repeated paracentesis had resulted in some absorption of fluid, and it was thought that something should be done to aid it. The oxygen replacement seemed to have an effect in lowering the temperature.

## THE PSALM OF A MEDICAL STUDENT.

WHOSE ANATOMICAL AND PHYSIOLOGICAL CONCEPTIONS DID NOT COINCIDE WITH THOSE OF HIS EXAMINERS.

(With apologies to Wadsworth.)

(? Ed., St. B. H. J.)



ELL me not in joyful numbers  
"Life is one long glorious dream!"  
For my soul is lead, and slumbers,  
And things are not what they seem.

Life is real! Life is earnest!  
And "The Rooms" must be its goal;  
"Fool thou wast, and fool returnest"  
Is the burden of my soul.

Not enjoyment, no, but sorrow  
Is our destin'd end or way;  
And to learn what by to-morrow  
Leaves us madder than to-day.

Art is long, and Time is fleeting,  
And our hearts, once stout and brave,  
Now, like huddled sheep, are bleating  
Fun'ral marches to the grave.

In the world's broad field of battle,  
In the bivouac of Life,  
We are like dumb, driven cattle,  
With a hard stake in the strife!

Trust no Future, rumour'd pleasant!  
Like the Past 'twill be as dead!  
Facts—Facts are the living present!  
Book in hand, exams ahead!

Lives of men who've "pass'd" remind us  
They have made their lives sublime,  
And have left their light to blind us  
As we tread the sands of time;

Sands that countless thousand others,  
Sweating hard, have plough'd in vain;  
Poor forlorn and despair'd brothers!  
Plough'd, and plough'd, and plough'd again!

Let us then be up and doing,  
With a heart for any fate;  
In the end, our lost youth ruing,  
We may qualify, though late.

A. E. R.

## AND ALL HIS WORKS.



"IN HER PSYCHIC PROJECTION OF MY BEING ACROSS SPACE."

**T**HE visitor burst into the room, stumbling over the door-mat. "The Devil," he cried testily. The Doctor raised his eyebrows for an instant at the intruder, and was confronted by a neatly built man with a pale, austere face, who took a seat by the window and gazed at the Hospital. The Doctor attempted a dignified rebuke.

"Won't you have a seat?" he said. The sarcasm was lost on the visitor.

"I have one." The accent was Occidental, and the Doctor's face expressed the apprehension of a confirmed talker who meets an American. He quickly reviewed the Special Departments set aside for the quiet entertainment of such people, and blanched, for none was open.

"Well?"

"I am a Martian," said the man, "visiting your planet. Having mastered your language and culture, I am examining your institutions." The Doctor was

a public school man, but there was a quality of the stranger's gaze that compelled belief. "Owing to a miscalculation on my wife's part—a wilful one, I fear—in her psychic projection of my being across space, I landed in a Middle Western State. I have, however, survived, though my accent betrays my experience."

The Doctor was too charmed by the modesty and good taste of the Martian's remarks to notice that they answered his unexpressed thoughts. "It is a pleasure to hear such essentially British sentiments, if you will pardon my presumption in so labelling them." The visitor bowed, without smiling.

"And you have met our great men?"

"I fear not. Only your famous ones."

There was modest assurance in the Doctor's next question.

"And how does our young planet compare with yours?"

"I have not yet finished my studies, but I have realized that since the quality of thought appears to be so dependent on the health of the thinker, the state

of medicine will be an excellent guide to the standard of civilization."

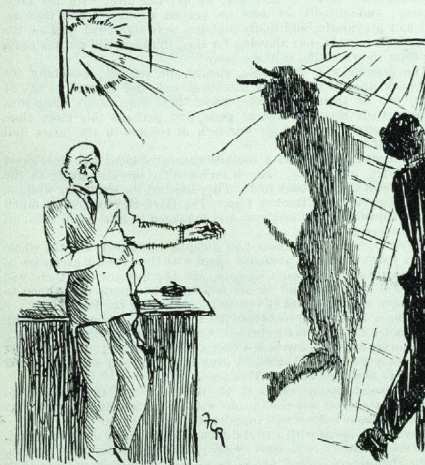
"Of course, we must appear to you as—picking up the pebbles on the—er—shores of vast seas of—." The Doctor tittered after the nervous manner of plain men misquoting their great. He had had a University education. "I mean, what progress has medicine made on Mars?"

The Martian knitted his brows. "Progress? Oh, I remember. It was one of the words banned from our language by the Act for the Suppression of Subversive and Obsolete Ideals."

"But surely knowledge, on so old a planet, must be immense?"

"Mere claptrap." The Martian waved his hand airily. "Wellsian claptrap," he added a little venomously. "Burroughs, I assure you, is the better liar. As for medicine, years ago we allowed doctors to advertise. The competition was so great that the work soon was in the hands of three great Trusts, which were so proficient that disease was in danger of becoming extinct, and pathogenic bacteria curiosities in the Central Museum. The embittered descendants of the Independent Research Workers, fearing a proletariat free from moral and biologic checks, publicly implored the Trusts to suspend their work for a decade or two. Life, they said, was becoming too simple, too vacuous. They were immediately dubbed Chaotics, and retaliated by calling their opponents Vacuists."

The Doctor was moved to be impressive. "You see,"



"COME, TELL ME WHO YOU REALLY ARE."

he said, "the evil of advertising." The spirit of Hospital seemed to enfold him in its complacent embrace.

"The Vacuists pointed out that the Central Museum would be a salutary reminder of a less happy state, and proposed the institution of a compulsory periodic visit for the poorer classes, which should, on these occasions, give freely towards the upkeep of the Museum." The Chaotics, angered and shocked, condemned the soul-destroying simplicity, saying life without disease was not perceptible as life at all, and started a 'Back to the Complex Life' movement."

The assured tone of the recital nettled the long-silent Doctor. He felt assertive. "Simplicity, of course, is the most desirable." His upbringing had been orthodox, by rich but honest parents.

"Not at all." The stranger looked around. "For instance, had you been a Vacuist, you would have had no mat at the door. I should not, therefore, have given way to that reflex expletive it occasioned as I entered. You would then have had nothing to give the lie to my somewhat inhuman austerity. Cowed, your conversation would have been even more fatuous. You see?"

The Doctor remembered he was a gentleman. "Cynicism would appear to be misplaced upon such an occasion, sir."

The Martian waited until the Doctor had finished, then continued evenly.

"The Vacuists were defeated, simply enough, by a revolution. The slogan was 'Simplicity to end simplicity.' After the storming of the Museum bacteria were disseminated, all records of thoroughly effective therapy destroyed, and Mars became complex, primitive and happy."

"Monstrous," cried the Doctor. "A deliberate return to barbarism? Impossible! You, sir, can hardly be in your right mind to say such things unmoved. What brutes!"

"My ancestors," yawned the stranger, "were Chaotics. Though I agree with them fundamentally, I think they regressed too far, and became too bestial. Indeed, that was why my wife persuaded me to try the Earth for a while. I wanted to go to Venus. We had a row. She said Venus was vulgar, and only cinema stars and pickle manufacturers wintered there. In a fit of pique she landed me in Wyoming." His voice grew determined. "I shall go to Venus, though." He stared, pallid and bored, through the window at the Hospital. "For all the change I get here, I might as well be on Mars."

The Doctor felt that his faith was being undermined, and his spirit rallied to defend it as well as he knew. He blustered.

"We bestial? Fellow, do you dare to—" He

suddenly quieted, realizing that a Martian was an impossibility. The madman, or Communist, or whatever the fellow was, must not be allowed to corrupt the morals of weaker minds than his. He advanced on the man firmly, quelling sudden misgivings. He grasped nothing but the traditional thin air, and was only partly relieved to see the fellow had merely slipped towards the door. His voice trembled as he called out coaxingly:

"Come, tell me who you really are."

The stranger smiled disturbingly over his shoulder, forgot the mat, and again stumbled over it.

"Oh, the Devil," he said, testily.

M.

## STUDENTS' UNION.

### THE NEW ARRIVAL.



HAVE been requested by the Editor to write a few words for the enlightenment of this year's new students on the sporting prospects open to them; for this reason I do not feel quite as well disposed towards the Editor as I did two days ago.

New students may be divided into two groups from the games standpoint—those who have just come up from school, and those who have completed their first three or four years of study at one of the Universities.

In both cases the majority will have spent a large part of their time at games of one sort and another, and will be anxious to know how and where they can continue these activities, and that is the point on which I will attempt to enlighten them.

To begin with everyone should attend the Freshmen's tea, to be held in the Library, the date of which will appear on the notice-board shortly; there the names of the Secretaries of each club will be announced, with the request that all wishing to take part will give in their names there.

The Hospital ground is at Winchmore Hill, tickets 1s. return at the Cloak-Room, and can be reached by train from King's Cross or Farringdon Street. There at the moment can be had Rugby, Soccer and Hockey *ad lib.* All the clubs runs several teams, and no one need be afraid of being thought "too bad," or shy about trying to learn a new game.

Ample accommodation for dressing and bathing is provided in the spacious pavilion, and liquid refreshment, hot or cold, can be had from the counter, presided over by our venerable if slightly rubicund patriarch, Bill.

The winter over, the ground is handed over to the less strenuous pursuits of lawn tennis and cricket, both

of which may be had in bulk, and are excellently provided for, even if the tennis-courts are a little damp at times.

Between these seasons the ground is given over to athletics, and it is on this subject that I wish to have my chief word. This year we should have won the Inter-Hospital Athletic Cup and we failed to do so; the reason I am not prepared to give, but I do appeal to all those who have any talent whatever in athletics to make a little sacrifice when the time comes next spring and do their very best to regain the Cup.

For the last four years we have had in our midst one of the greatest athletes of all time in H. B. Stallard. Unfortunately we are losing him in the near future, and it is up to us to carry on his work with the keenness and self-sacrifice that he has always shown.

A word of games not played at Winchmore Hill. A fives court lives behind the Dispensary, and though usually covered with the dust of untold ages, it provides good exercise for the untrained.

In conclusion, if any of our Freshmen should happen by any chance to read this attempt to enlighten them, I hope he will realize that we offer him the very heartiest welcome, and trust that he will join in the life of the Hospital to the best of his various abilities.

R. H. BETTINGTON.

### HOCKEY PROSPECTS.

At the beginning of another season it is as well to glance over our record of last year. The team was very successful during the first half of the season, even though we lost our captain, W. A. Briggs, one of the best backs the Hospital has turned out for years. After the Christmas vacation, however, we did not meet with the same success; undoubtedly we were up against stronger teams than we had met previously, and many matches were scratched because the grounds were unfit, but allowing for this, the team did not maintain the form shown earlier in the season.

The defence was, as a rule, steady and reliable, especially the half-back line; the forwards combined well and showed plenty of dash, but in their opponents' circle they were rarely dangerous because their shooting was so poor, and perhaps this more than anything else accounted for our lack of success in the latter half of the year.

The second eleven had a most successful season, and developed into a very useful side. The team owed its success largely to the excellence of the half-back line. They finished the season by winning the Junior Hospital Hockey Cup. The third eleven showed much more enthusiasm than last year and managed to field a full team on nearly every occasion.

K. W. D. Hartley at centre-half is captain this year, and the whole of last year's defence is available again with the doubtful exception of J. H. Attwood, last year's captain. In the forward line there will be several vacancies, and we are hoping to find some useful men to fill these from the second eleven and from among the Freshmen.

We have an attractive fixture list this season, among them being Emmanuel College at Cambridge, Christ Church, Oxford, R.M.C., Sandhurst, and St. Lawrence College. We are determined to build up a really useful, well-balanced team this year, and we shall do our utmost to win the Cup from Thomas's.

The second eleven under G. H. Bradshaw and the majority of last year's players are sure to do well again, and it is hoped that H. F. Bateman will be well supported again this year.

The season opens with a trial match at Winchmore on October 1st. Will all Freshmen who play hockey, and any other new players, make themselves known to the Secretary by quickly putting their names on the list on the Hockey board?

## CRICKET.

### ST. BARTHOLOMEW'S HOSPITAL v. GUY'S HOSPITAL.

#### Cup Final.

BART'S met GUY'S in the final for the Inter-Hospitals Cricket Cup on Guy's ground at Honor Oak on July 23rd and 24th. Bart's won the toss and went in to bat and were dismissed for a good score of 227, the chief scorers being Mackie and Sinclair, each making 66.

Guy's then went in, and at the close of play on the first day had made 205 for the loss of 7 wickets.

Curtis and Eustace opened the batting for Guy's the next day. Guy's were all dismissed for 240 before lunch. The chief scorers for Guy's were: Pye-Smith 58, Curtis 46 not out, Williams 39.

Cook and Parker opened the second innings for Bart's. Only five reached double figures and were all dismissed for a poor score of 125.

Guy's went in and soon knocked off the runs for the loss of 4 wickets, Pye-Smith scoring 20 and Curtis 33 not out. In doing this Guy's won the cup and we heartily congratulate them.

ST. BART'S.		GUY'S HOSPITAL.	
First Innings.	Second Innings.	First Innings.	Second Innings.
N. F. Cook, c Hutchinson, b Dun	15	b Dun	20
G. A. Y. Parker, c Dun, b Curtis	23	b Dun	0
R. H. Bettington, c Hutchinson, b Curtis	0	c Pye-Smith, b Clarke	2
K. W. Mackie, run out	66	b Dun	16
M. R. Sinclair, c Garland, b Curtis	66	c Garland, b Williams	16
C. B. Prowse, c Spence, b Curtis	25	c Dun, b Williams	27
W. F. Gaisford, b Curtis	0	not out	30
J. H. Pierre, not out	7	b Curtis	0
H. L. Hodgkinson, c Curtis, b Williams	4	b Curtis	1
J. O'Connell, c Garland, b Curtis	4	lbw, b Curtis	3
J. B. Bamford, lbw, b Williams	0	run out	2
Extras	17	Extras	18
Total	227	Total	125

### GUY'S HOSPITAL.

First Innings.		Second Innings.	
E. J. Pye-Smith, lbw, b Bettington	58	b Hodgkinson	30
T. Garland, b Bettington	21	lbw, b Bettington	10
G. Ensor, b Hodgkinson	10	lbw, b Bettington	16
L. S. Williams, b Bettington	39	lbw, b Hodgkinson	0
A. H. Curtis, not out	46	not out	33
H. Spence, b Bettington	0	not out	17
G. L. Clarke, b Hodgkinson	15		
J. Dun, c Parker, b Hodgkinson	0		
L. Eustace, b Bettington	7		
J. Gare, b Bettington	4		
J. Hutchinson, b Bettington	4		
Extras	35	Extras	12
Total	240	Total (4 wkts.)	113

Bowling.—1st innings: Bettington, 7 for 104; Cook, 0 for 49; Hodgkinson, 3 for 46; Sinclair, 0 for 21.

2nd innings: Bettington 2, for 45; Cook, 0 for 19; Hodgkinson, 2 for 26; Sinclair, 0 for 7.

### RUGBY FOOTBALL CLUB.

LOOKING back at last season may not at first appear to be a happy thing to do. We think of ourselves being knocked out of the cup-ties in the semi-final round. We remember a large number of matches lost and few won. If we look further, though, things were not all sad. It is true that we won few matches, but we lost many close games, many of them against good sides too. An odd feature of our season was the fact that we drew three matches. Looking still further we can cheer up still more. The "A" retained their cup, just winning in a most exciting final against St. Mary's. Also, in spite of many scratched fixtures, they had a very successful season. The three other teams also suffered from many blank Saturdays, but enjoyed an average season. Tabulated, the records of the first two teams reads:

## Points

Played.	Won.	Drawn.	Lost.	For.	Against.
1st XV . . . 35	12	3	20	345	361
"A" XV. . . 24	17	0	7	310	175

To look forward to the season which has just started we notice changes in our personnel. Dr. Wilfred Shaw is among our vice-presidents. The strong gynaecological element on our committee need fear no busman's holiday, anyway, at the matches. R. N. Williams is our new captain. We take this opportunity to wish him a most successful season, both with his team and individually. A. H. Grace is undertaking the strenuous and thankless task of secretary. C. R. Jenkins after his excellent work as secretary last year is vice-captain. We are all very sorry that E. S. Vergette, last season's captain, must now retire after his seven years of most useful work for the club. R. H. Bettington will not be able to play until next month in any case, and he is not certain even then. We shall miss M. L. Maley in every way, perhaps most noticeably in the line-outs. Perhaps the loss that we shall feel most will be the retirement of T. P. Williams. Can we ever find a scrum-half who will do all he did as well as he did?

Severe as our losses appear and difficult though the gaps may be to fill, we need by no means despair. We have most of last year's "A" side available. There is every reason to expect that we shall be able to command a very useful pack of forwards. Outside the scrum we shall experience our perennial difficulty.

The fixture list differs in a few particulars from last season's, though on the whole it is very similar. We play Rosslyn Park instead of Blackheath. Nuneaton do not appear on this season's list. A match arranged which is not on the printed list is that against the R.N. Engineering College, Keyham, which will be played on the Monday following the away match against the Devonport Services. Redruth is a new fixture. This season the fixtures are arranged very much better than they were last season. This arrangement should contribute much to the enjoyment and success of the season.

Finally we would say a word concerning Freshmen. We say "would" advisedly. At the moment of writing we know nothing "in advance" of those who will join us with this JOURNAL. This may be a good omen. So often have we heard of stars that have failed to appear, while others have failed to shine. Let us, then, if we may do so with all modesty, advise all Freshmen who may have any doubts about doing so to join the club and enjoy themselves. All the Freshman need do is to find Grace and give him his name. For your benefit and welcome, then, Freshmen, Grace is the handsome, Auburn-haired Apollo to be seen probably in the "Rooms" working hard.

P. G. LEVICK,  
Hon. Treasurer.

### CITY AND HOSPITALS CHARITY ATHLETIC CONTEST.

OUR readers will be interested to hear that the financial result of this year's City and Hospitals Charity Athletic Contest, between the Banks, Insurance Offices, Stock Exchange and the United Hospitals, will mean the dividing between the Hospitals comprising the U.H.A.C. of £260. This is the largest amount yet distributed. Our Senior Physician, Dr. Morley Fletcher, the President of the Contest this year, is to be congratulated on the result.

## CORRESPONDENCE.

### THE LIBRARY.

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

DEAR SIR,—The authorities who take their holidays from July to September doubtless imagine the Hospital deserted during their absence, and so, in spite of annual grumblings, the Library is closed for the whole of August, and the keen student running the Hospital in the absence of his superiors has nowhere either to work or sleep. But when indeed it is reopened, is it fit for habitation? Most emphatically, no! The ceiling is being distempred, and the chairs and tables receive as much distemper as the ceiling; scaffolding is

dismantled from one end and erected at the other, and above all the din mate calls to work with that sublime disregard of his surroundings peculiar to the British workman.

Perhaps he, too, has all August on holiday—or have the authorities any better explanation?

I am, Sir,  
Yours faithfully,  
W. K. P.

The Library,  
St. Bartholomew's Hospital, E.C. 1;  
September 7th, 1927.

#### THE CHRISTIAN UNION.

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

DEAR SIR,—Will you kindly insert in the JOURNAL the list of our fixtures for the forthcoming term, and may I draw special attention to the meeting for Freshmen on Tuesday, October 17th? The meetings are held in the Library at 5 p.m., and there is a daily meeting for prayer in the Chapel from 1.5 to 1.25 p.m.

Tuesday, Oct. 11.	Fresher's Squash.	Tea 5 p.m.	Dr. Orissa Taylor.
Thursday, .. 20.	Mr. Montague Goodman.		
.. .. 27.	Rev. E. Y. Bate.		
.. Nov. 3.	Rev. E. L. Langston.		
.. .. 10.	Mr. Godfrey Buxton.		
.. Dec. 1.			
.. .. 8.			
.. .. 15.	Mr. George Goodman.		

Yours truly,  
J. W. C. SYMONDS, Hon. Sec.

St. Bartholomew's Hospital, E.C. 1;  
September, 10th, 1927.

#### READERS' OPINIONS.

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

SIR,—By reading the JOURNAL one hopes to hear of "what's doing" inside the dear old walls, the outside of which even some of us have not much chance of seeing.

Though grey, it was never grim; may it never be, nor the paper that chronicles its affairs. One wants to hear what men are laughing over and yarning about, quite as much as what perplexities they come up against.

The doings of the clubs and of individuals are matters of keen interest, even to those of us who have little staying power beyond what a slow fox-trot calls for.

What books to read (and avoid) is one of the most useful things the JOURNAL does for us in its reviews. Lastly, one hopes always to find in the JOURNAL a means of keeping up with advances in medicine useful in the daily round of practice, and this the series of promised Annotations on diagnosis, treatment and technique from the clinical and laboratory point of view should provide.

I am, Sir,  
Yours very truly,  
VIEUX ROUTIER.

September 11th, 1927.

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

DEAR SIR,—I was indeed gratified to read the letter in your September number over the signature "A Subscriber," who, I feel, is in entire agreement with me. He put the matter very beautifully and I hope our letters will bear fruit.

The next letter—M.'s "reply"—forms a marked contrast, consisting almost entirely of egotism punctuated by exclamation marks, and, as he admits, "a vulgar snarl or two." With great difficulty I picked out from this fandango a challenge to indicate the place where his "menacing qualities are displayed." Fortunately I have on my desk the June number in which appeared a particularly annoying ebullition, entitled "Nephros" to give it a classical flavour, though the great Kipling whom it was intended to parody was quite free of this weakness. One is at first tempted to attack it systematically over many pages, but rapidly comes to the conclusion that a busy man's time is not to be so spent. Just two points then:

(1) The conception of the birth of a cell without previous division of a parent cell which permeates the article strikes at the root of modern cytology; and (2) that extraordinary paragraph containing amongst a deal of the *John Bull* type of invective, "You cross-bred son of a prophetic anomaly." What does it all mean? A thoroughly muddled and misleading mind!

Yours faithfully,  
W. K. P.

[Our contributor replies: "Intelligent study of Kipling's prose style will reveal a trick of sacrificing logical truth to the maintenance of a fine, nervous narrative, while in no way losing an air of omniscience. If, then, my parody is to be given credit for being honourable in intention, not only does W. K. P.'s first point become pointless, but it reveals an ignorance of the 'great' works the parody of which he considered himself competent to judge.

"Besides, a student who required to be told that cells usually propagate their kind by division would probably need a night-light and a good-night reassurance that cells didn't really talk like that.

"The second point is puerile.

"It is a pity that moral enthusiasm should have driven W. K. P. from the safe heights of hearty prejudice into the morass of somewhat unbalanced criticism of once despised 'literary frills.' But one word of thanks. W. K. P.'s idea (for it is none of mine) that a Greek name gives a classical flavour illuminates the possible character and motives of the gentleman who sought to advance the art of medicine by calling rickets rachitis."—ED., *St. B. H. J.*]

#### REVIEWS.

RECENT ADVANCES IN OPHTHALMOLOGY. By W. S. DUKE-ELDER. Pp. 328. 4 coloured plates and 73 figures in the text. Price 12s. 6d.

If the other volumes of Churchill's "Recent Advances" series are in any way comparable with this book, the publishers may congratulate themselves upon having filled a niche in medical literature which will be greatly valued. The mass of recent work, and still more of recent literature, is great, and, as is always the case, much of it will not stand the test of time.

In such circumstances a discriminating discernment is necessary in order to pick out that which has effected some definite advance, however slight, and this selection Mr. Duke-Elder has made with care and critical judgment.

It is satisfactory to note that Mr. Duke-Elder is not disposed to include the present vogue of focal infections with the widespread removal of teeth and tonsils and intestinal lavage under the head of "advances."

It is not possible to give any adequate idea of the subjects dealt with, but if one mentions the few following, it should give some indication of the scope of the book: The Action of Light upon the Eye, Embryology, Biomicroscopy, The Slit Lamp, Examination by Red-Free Light, The Intra-ocular Pressure, Operative Advances, The Visual Powers and Centres, Intra-ocular Fluids, and a great deal besides.

Mr. Duke-Elder has given a good *résumé* of his own excellent work. The whole get-up of the book is admirable, it is written in a most interesting manner, and one may confidently predict that a further edition will soon be called for.

ACTINOTHERAPY FOR GENERAL PRACTITIONERS. By H. G. FALKNER, L.R.C.S.I., L.R.C.P.L., L.M., O.B.E. (London: Baillière, Tindall & Cox, 1927.) Price 7s. 6d.

In the subject of actinotherapy it can be truly said "of making many books there is no end." The present work is still another which does little or nothing to advance the knowledge of the subject, and with the exception, perhaps, of a detailed discussion on the relative merits of various types of protective goggles, presents no new feature.

A large section of the book is given up to descriptions and illustrations of numerous types of lamp. There is no indication of primary or running costs of the different models, which one can well believe might be of importance to the practitioner for whom it is written,

and guidance as to the merits of the various types is vague and inconclusive.

One can readily believe that the author is a clinical enthusiast rather than a scientist when one reads the following:

"... in treating a patient with my big raying lamp he brought to my notice that he could see the bones of his foot reflected on the wall 'like X-ray' as he described it. On testing this phenomenon and throwing a shadow upon a white wall, it was found that the bones of the forearm and hand were distinctly visible. . . ."

This ignores the fact, generally accepted by physicists, that ultra-violet rays are absorbed by a very thin layer of tissue, nor does it explain how an invisible ray can throw a visible shadow on a non-fluorescent surface.

The last 60 pages are devoted to consideration of the disorders which can be treated by actinotherapy with more or less successful results. After warning his readers against making excessive claims for ultra-violet rays, the author rather takes the point from his remarks by himself claiming results which are at any rate not in accordance with the experience of other workers. The omission of a number of the diseases mentioned in his long list would add rather than detract from the value of the work.

It is difficult to see what particular gap in the literature of actinotherapy is usefully filled by this book.

PRACTICAL ORGANIC AND BIO-CHEMISTRY. By R. H. A. PLIMMER, D.Sc. New edition. (London: Longmans, Green & Co., Ltd., 1926.) Pp. x + 568. Price 21s. net.

The earlier editions of this book have been well known for many years past to all students who have studied organic chemistry in this Hospital, who have found them to be of special service in their laboratory work. In this new edition theoretical considerations have been more fully developed in dealing with many classes of compounds, so that the book is more readable as a text-book, which was one of the objects of the author in bringing out this new volume. Some portions of the older book dealing with plant chemistry have been omitted, and in their place appear sections which will be of more immediate interest to the medical reader, such as those on vitamins and respiratory exchange. There is, too, a description among the polypeptides of glutathione, a substance of great interest to bio-chemists on account of its function as an oxidation-reduction system. Quantitative processes of analysis are well described, including those for blood and urine, although only one method for the estimation of blood-sugar is given. This volume is sure to prove to be of as much value to present-day students as former volumes have proved to be to their predecessors.

OUTLINES OF DENTAL SCIENCE. Vol. III, Dental Materia Medica, by PROSPER H. MARSDEN, M.Sc., Ph.C., F.C.S. Pp. 155. Price 7s. 6d.

Vol. IV, Dental Prosthetics, by J. DOUGLAS LOGAN, L.D.S. Pp. 224. 14 illustrations. Price 7s. 6d.

Vol. V, Dental Radiography, by CHARLES A. CLARK, L.D.S. Pp. 120. 50 illustrations. Price 7s. 6d. (London: E. & S. Livingstone, 1926.)

These three little volumes are excellently produced. Their bindings are substantial, the paper is of fine quality and the type large and clear, while vols. iv and v are profusely illustrated with diagrams and photos.

In vol. iii the author endeavours to give just sufficient information to satisfy the requirements of the dental student, and to this end all superfluous matter is rigidly excluded. Our chief criticism is that this paring down may have been carried too far; but, if the book is used in conjunction with a copy of the *British Pharmacopœia*, any deficiency in this respect would be eliminated. A specially good feature is the mass of really useful information as to the practical use of the drugs described, and this should make the book useful to the practitioner as well as the student.

In vol. iv the author attempts to describe in the smallest space possible the various processes used in the mechanical laboratory for the construction of artificial teeth, and he has succeeded in doing this in extraordinary detail.

The clinical or chair-side aspect of dental mechanics is purposely excluded, in order, as the author says, to avoid confusion, and because the student begins his training with a laboratory course. This may be wise, but it considerably restricts the utility of the book, and

without a sub-title indicating its partial character the title becomes somewhat misleading.

One cannot help regretting that the author, with such a capacity for clear detailed description, should not have included some account of chair-side procedure, and also a chapter on modern denture design.

Vol. v: This little treatise contains a concise yet detailed description of the apparatus used in dental radiography together with the technique employed.

The chapter on technique also contains much practical and useful information on the handling of patients, culled from the author's long experience.

The description of the author's technique is very clear and complete, with the possible exception that he might have said more about correct angles to ensure undistorted negatives. It is here that the experienced meets most of his failures, and this part of the technique is by far the most difficult to master.

In addition to dental students and practitioners, the book should be very useful to the general practitioner who is occasionally called on to take dental radiographs.

A HANDBOOK OF OPHTHALMOLOGY. By HUMPHREY NEAME and F. A. WILLIAMSON-NOBLE. (London: I. & A. Churchill.) Price 12s. 6d.

In their preface to this book the authors state that it is written, primarily, for the undergraduate student and the general practitioner. As such it undoubtedly fulfils its purpose, but for a more advanced reader it is, perhaps, a little too brief.

The first chapter gives a very lucid description of examination of eyes, both external and internal; this is followed by "errors of refraction," which is clearly written but rather short. The following chapters deal systematically with various parts of the eye. A noteworthy omission occurs in a diagnostic table of acute iritis and acute glaucoma; no mention is made of the marked rise of tension which occurs in the latter condition.

One of the most striking and most pleasing features of the book are the illustrations and coloured plates. The latter are really excellent, especially the drawings of the various pathological fundi. All the illustrations are prepared by the drawing department of Theodore Hamblin, Ltd.

For practitioners who are intending to do some ophthalmic work as a "side line," and for students who desire to acquire more knowledge than is, perhaps, necessary for a general surgical examination, this book can be thoroughly recommended.

AIDS TO GYNAECOLOGY. By R. E. TOTTENHAM, M.D., D.P.H. (Dubl.), F.R.C.P.L., Professor of Obstetrics and Gynaecology, University of Hong-Kong. (London: Baillière, Tindall & Cox.) Pp. 132. Price 3s.

It is impossible to perceive what useful purpose this little book could serve. In many books of the synopsis type are invaluable to the student, but in this one the gaps are so many that perhaps it would be charitable to presume that gynaecology pursues a different course out East. A just criticism, of necessity, would be longer than its subject-matter. The illustrations, luckily, are few.

THE PHARMACOPEIA OF THE QUEEN'S HOSPITAL FOR CHILDREN, HACKNEY ROAD, 7th edition. (London: H. K. Lewis & Co., Ltd., 1927.) Pp. x + 89.

The new edition of this *Pharmacopœia* remains essentially the same as the last edition. Several new mixtures have been added, as well as a list of solutions suitable for intravenous infusion.

The book contains several sections detailing the instructions issued to parents for dealing with the commoner maladies of childhood in the home. While the majority are admirable, the section on the causes and prevention of diarrhoea is much too complicated to be easily understood, and could be simplified with advantage.

As the various preparations are supposed to be arranged in alphabetical order, one would have expected to find "Salis" before "Saponis" instead of after, as appears in this edition.

DRUGS AND DOSES. By DORA VINE. Price 1s. 6d. net.

This book should prove very popular amongst the nursing profession, its extremely low price bringing it within reach of all. It is arranged in a simple manner and contains many practical suggestions, together with a schedule of poisonous drugs and their antidotes. As a reference book it should be useful to those engaged in private nursing.



## RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

- ATKINSON, E. MILLS, F.R.C.S. "Nasal Headaches." *British Medical Journal*, August 13th, 1927.
- BARNES, E. BROUGHTON, F.R.C.S. (Edin.) (and Sir CHARLES BALLANCE, K.C.M.G., M.S., F.R.C.S.). "Anastomosis of Recurrent Laryngeal to Phrenic Nerves: Some Recovery of Function." *British Medical Journal*, July 30th, 1927.
- BARTON, J. KINGSTON, M.R.C.P. (Lond.). "Discussion on Tuberculosis in Wild Animals as compared with Man." *Proceedings of the Royal Society of Medicine*, January, 1927.
- "On Diaphyseal Aclasia," discussion at Clinical Section, *Proceedings of the Royal Society of Medicine*, January, 1927.
- "On Rickets," Section of Disease in Children. *Proceedings of the Royal Society of Medicine*, March, 1927.
- "Discussion on Light Treatment in Surgical Tuberculosis." *Proceedings of the Royal Society of Medicine*, April, 1927.
- "Discussion on Migraine," Section of Medicine. *Proceedings of the Royal Society of Medicine*, May, 1927.
- "On Twins," Section of Disease in Children. *Proceedings of the Royal Society of Medicine*, June, 1927.
- "Discussion on the Prevention of Scarlatinal Nephritis," Section of Medicine. *Proceedings of the Royal Society of Medicine*, July, 1927.
- "Discussion on Oral Manifestations in Systemic Disease in Children," Joint Section of Odontology and Disease in Children. *Proceedings of the Royal Society of Medicine*, July, 1927.
- "Diaphyseal Aclasia," Section of Disease in Children. *Proceedings of the Royal Society of Medicine*, August, 1927.
- BROCKMAN, R. STRLEGER, M.A., M.Chir., F.R.C.S. "Arria and Gale Lectures on the Tokamia of Acute Intestinal Obstruction." *Lancet*, August 13th, 1927.
- CAMMIDGE, P. J., M.D., M.R.C.S., L.R.C.P. "Chronic Hypoglycaemia." *Practitioner*, August, 1927.
- CHAMBERS, C.V., F.R.C.S. "Ovarian Hemorrhage from Ruptured Blood Cyst." *British Medical Journal*, September 17th, 1927.
- CHANDLER, F. G., M.D. (and CARLYLE T. POTTER, M.D.). "Result of X ray Treatment of Primary Malignant Intrathoracic Tumours." *Lancet*, September 17th, 1927.
- GIUSEPPI, P. L., M.D., F.R.C.S. "The Diagnosis of the Subacute Abdomen." *Practitioner*, September, 1927.

## EXAMINATIONS, ETC.

### UNIVERSITY OF OXFORD.

The following degree has been conferred:  
B.M.—Clüver, P. F.

Final Examination for Degree of B.M., B.Ch., July, 1927.

Medicine, Surgery and Obstetrics.—Clüver, P. F.  
Pathology.—Gilding, H. P., Walter, W. J.  
Forensic Medicine and Public Health.—Kingsley, A. P.

### UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:  
M.Chir.—Corbett, R. S.  
M.B. and B.Chir.—Alexander, G. L., Tanner, G. M., Nelson, H. P.  
B.Chir.—Watts, C. F.

### ROYAL COLLEGE OF PHYSICIANS.

The following has been admitted a Member:  
Emmons, K. V. B. (omitted from list published in September issue).

### ROYAL COLLEGE OF SURGEONS.

The following were successful at the Examination held for the Primary Fellowship, June, 1927:  
Boyd, H. C., Buckley, W., Förrester Wood, W. R., Freeman, E. A., Harris, H. E.

### ROYAL COLLEGE OF PHYSICIANS AND SURGEONS.

#### D.T.M. & H.

The Diploma in Tropical Medicine and Hygiene has been conferred on the following:  
Alexaude, G. L., Landau, J. V., Steel, C. R.

## CHANGES OF ADDRESS.

- ANDERSON, H. G., The Medical School, The University, Adelaide, S. Australia.
- BELL, K. DIGBY, Surg.-Commr. R.N., The Royal Naval Club, Portsmouth.
- CHAMBERLAIN, A. G., Chatham, Dorset.
- HOOKS, G. F., Lt.-Col., I.M.S. (ret.), Bangalore United Service Club, Bangalore.
- HINE, T. G. M., Start House, Slapton, S. Devon.
- HOLMES, J., 54, Houghton Street, Southport, Lancs.
- HOWELL, H. B., "Carningle," Aberporth, Newcastle Emlyn, Cardiganshire.
- HUME, J. B., 86, Harley Street, W. 1. (Tel. Langham 2186.)
- JEPHCOTT, A., "Winterslow," Southbury Road, Enfield, Middlesex.
- KELLOND-KNIGHT, H., Surg.-Capt. R.N., 19, King's Avenue, Eastbourne.
- MAXWELL, J., 8, Harley Street, W. 1. (Tel. Ambassador 0684.)

## APPOINTMENTS.

- ANDERSON, H. G., M.D., M.R.C.P., appointed Pathological Registrar to the Medical School, Adelaide University, S. Australia.
- CAFFEY, F. C. W., F.R.C.S., appointed Surgeon to the Ear, Nose and Throat Department, with Charge of Out-Patients, Willesden General Hospital.
- DAVIS, H. HALDIN, M.D., F.R.C.S., appointed Physician Dermatologist to Bollingbroke Hospital, Wandsworth Common.
- IMANSTON, F. F., D.S.C., M.R.C.S., L.R.C.P., appointed Surgeon in Charge of Out-Patients, Medico-Surgical Institute and University Polyclinic, Parc Leopold, Brussels.
- MAXWELL, J., M.D., M.R.C.P., appointed Physician to Out-Patients, Royal Chest Hospital.
- SIMPSON, D. P., M.R.C.S., L.R.C.P., appointed House Physician to Warneford General Hospital, Leamington Spa.
- VINER, G., M.D., F.R.C.S., appointed Assistant Ophthalmic Surgeon to Bollingbroke Hospital, Wandsworth Common.

## BIRTH.

ROSSDALE.—On September 8th, 1927, at 57, Upper Berkeley Street, W. 1, to Kate, wife of Dr. George Rossdale—a son.

## MARRIAGES.

- CRISP—AINSLY.—On September 6th, 1927, at the Parish Church of Danby-in-Cleveland, by the Rev. P. R. Turner, Vicar of St. Paul's, West Hartlepool, Gordon, son of R. L. Crisp, of Elm Park Road, Chelsea, to Joan, daughter of Dr. and Mrs. Ainsley, of Greylands, West Hartlepool.
- FORD—PEAKE.—On August 24th, 1927, at the Parish Church, by the Rev. Canon Horace Monroe, assisted by the Rev. F. E. Ford, J. Norman C., elder son of Dr. Frank C. Ford, of Wimbledon, to Audrey, elder daughter of the late Dr. W. H. Peake and Mrs. Peake, of 32, Cottenham Park Road, Wimbledon.
- WILSON—TAYLOR.—On August 26th, 1927, at the Friends' Meeting-House, Letchworth, Henry Leonard Wilson, M.B., M.R.C.P., to Ruth Lotherington Taylor.

## DEATHS.

- DAVEY.—On September 9th, 1927, at 26, South Parade, Southsea, Dr. Ernest H. Davey, third son of the late R. Staines Davey, M.D., J.P., of Walmor, Kent.
- NIXON.—On July 15th, 1927, after an operation, Horace Chulow Nixon, M.D., of Queen's Parade, Bath.
- PAGET.—On September 11th, 1927, at Great Houghton House, near Northampton, Charles Edward, son of the late Sir George Paget, K.C.B., aged 68.

## 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, E.C. 1.

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLIAMS, M.B.E., B.A., at the Hospital.

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0510.

# St. Bartholomew's Hospital



## JOURNAL.

"Æquam memento rebus in arduis  
Servare mentem."

—Horace, Book ii, Ode iii.

VOL. XXXV.—No. 2.]

NOVEMBER 1ST, 1927.

PRICE NINEPENCE.

## CALENDAR.

- |                |   |
|----------------|---|
| Tues., Nov. 1. | —Sir P. Hartley and Mr. McAdam Eccles on duty.  |
| Wed., " 2.     | —Surgery. Clinical Lecture by Mr. McAdam Eccles.  |
| Fri., " 4.     | —Sir Thomas Horder and Mr. L. B. Rawling on duty. Medicine. Clinical Lecture by Dr. Morley Fletcher.  |
| Sat., " 5.     | —Rugby Match v. Aberavon. Away. Hockey Match v. Emmanuel College, Cambridge. Away.  |
| Mon., " 7.     | —Special Subject. Clinical Lecture by Mr. Rose.   |
| Tues., " 8.    | —Dr. Langdon Brown and Sir C. Gordon-Watson on duty.  |
| Wed., " 9.     | —Surgery. Clinical Lecture by Mr. L. B. Rawling.  |
| Thur., " 10.   | —Abernethian Society. Clinical Evening at 9.30 in the Abernethian Room.   |
| Fri., " 11.    | —Prof. Fraser and Prof. Gask on duty. Medicine. Clinical Lecture by Sir Percival Hartley.   |
| Sat., " 12.    | —Rugby Match v. London Welsh. Home. Association Match v. Old Owens. Home. Hockey Match v. Hendon. Away.                                     |
| Mon., " 14.    | —Special Subject. Clinical Lecture by Mr. Elmslie.  |
| Tues., " 15.   | —Dr. Morley Fletcher and Sir Holburt Waring on duty.  |
| Wed., " 16.    | —Surgery. Clinical Lecture by Mr. L. B. Rawling.  |
| Fri., " 18.    | —Sir P. Hartley and Mr. McAdam Eccles on duty. Medicine. Clinical Lecture by Dr. Langdon Brown.   |
| Sat., " 19.    | —Rugby Match v. Bristol. Away. Association Match v. Old Mercers. Home. Hockey Match v. Hornsey. Home.                                       |
| Mon., " 21.    | —Special Subject. Clinical Lecture by Mr. Scott.  |
| Tues., " 22.   | —Sir Thomas Horder and Mr. L. B. Rawling on duty. Last day for receiving matter for the December issue of the Journal.                      |
| Wed., " 23.    | —Surgery. Clinical Lecture by Sir C. Gordon-Watson.   |
| Thur., " 24.   | —Abernethian Society. Address by Prof. Hartridge on the Subject, "Sleep." Rugby Match v. United Services (Aldershot). Away.                 |
| Fri., " 25.    | —Dr. Langdon Brown and Sir C. Gordon-Watson on duty. Medicine. Clinical Lecture by Sir P. Hartley.  |
| Sat., " 26.    | —Rugby Match v. Devonport Services. Away. Association Match v. Keble College, Oxford. Away. Hockey Match v. Clare College, Cambridge. Away. |
| Mon., " 28.    | —Special Subject. Clinical Lecture by Dr. Cumberbatch.  |
| Tues., " 29.   | —Prof. Fraser and Prof. Gask on duty.   |
| Wed., " 30.    | —Surgery. Clinical Lecture by Sir C. Gordon-Watson.   |

## EDITORIAL.

**H**IS morning's fog, following as it does a few days of rain driven home by icy winds, reminds us that the season of infantile enteritis has definitely given place to the broncho-pneumonic epoch. It is of the utmost importance for the medical practitioner to adapt himself quickly to the first fog. The chest specialist must prepare for his winter season by a prolonged pro-œstrum of good food, rest, and new rubber parts for the stethoscope, just as a Swiss Winter Sports Hotel must complete the decoration for the ball-room and perfect the rink, or, by contrast, the Southend Bathing Hutment Syndicate must make sure that the cracks in their cabins are filled in to satisfy even the most peeping of town councillors. Our garage was rudely awakened from its summer of choked carburettors by the lorry that skidded through layers of plate glass into the best parlour behind the shop. Many a chauffeur's fracture will be sustained these cold mornings, slipped cartilages will form the natural sequela of the Rugby season, and the Port and the Colles will be greatly in vogue as the elderly Charleston on the wet leaves at the corner of the street. The keynote to the prevalent tone of the Surgery is given in a poem from the latest Milne-Shepard combination, "Now We are Six," which may save some examinees from suicide:

"All sorts and conditions  
Of famous physicians  
Came hurrying round  
At a run;  
They all made a note  
Of the state of his throat,  
They asked if he suffered from thirst;  
They asked if the sneezles  
Came after the sneezles,  
Or if the first sneeze  
Came first."

As an encouragement to study during the long winter evenings we may quote a serious note struck by Miss

Evelyn Laye recently under the heading of "Don't be just pretty." Miss Laye says: "For those who can't afford such expensive methods of being 'different' there is always education and study to fall back upon. These are the cheapest and best means by which all of you girls can make yourselves interesting." And she goes on to recommend the mastering of one or two languages, or music, or art, or science. This is surely better than just having an ordinary succession of French and Italians when it gets dark at 5, as we have been in the habit of doing.

No matter what your tastes are, one evening must be kept by all and sundry, and that is **Friday, December 2nd**, when the **Annual Dance** will be held at the Savoy Hotel from 9.15 p.m. until 2.30 a.m. The Savoy is well adapted to the entertainment of vast crowds, so don't let that deter anyone. No more excellent way of winning her heart or of showing her off could be devised. With such high thoughts in your heads tickets at 35s. double and 21s. single will appear cheap. Think what one could do in five hours and a ride home! Tickets and particulars may be obtained from the Secretaries, Messrs. R. H. Bettington and I. E. Phelps.

The *Old Students' Dinner*, held in the Great Hall on October 3rd, was, *quid pro quo* food and drink, a very excellent one. The Secretaries, Sir Charles Gordon-Watson and Mr. Vick, must be congratulated on the grouse pudding and on the wines (of which we vaguely remember sampling seven varieties). Dr. Morley Fletcher, as Chairman, made the only speech, the idea being that everyone should speak at once and adjourn early to the Library for that purpose. The Chairman gave a short recapitulation of the history of these Dinners—the record was held by a gentleman who survived his sixtieth. In welcoming the new Professor of Pathology and Physiology he rather happily mentioned that Dr. Hartridge, in addition to his special senses, was believed to have published a monograph on the sixth sense possessed by bats. He went on to appeal for a contributions fund to be used for the endowment of the Professorial Chairs, which is badly needed. Finally he welcomed the guests, who included Lord Stanmore, the "Brother Regii"—Sir John Rose Bradford and Sir Humphry Rolleston—Sir William Lawrence, Air-Marshall Monro, Wing-Commander Gaskell and other famous men and Governors of the Hospital. To judge from the buzz of conversation that could be heard through the Hospital until an early hour, many old friendships were cemented or resurrected.

In response to innumerable requests, a new edition of *Round the Fountain* is being prepared and should be through the Press by Christmas. Illustrations have been provided and some additions made. It is proposed to publish, in addition to the ordinary paper cover, a limited number of copies in cloth. Further particulars will be given next month.

For the photographs of the now vanished Christ's Hospital we reproduce in this number, we are much indebted to the Almoner whose skill in photography has to be seen to be believed.

We are able at last to publish an essay and to award a prize. The alternative subjects for next month are "**Brighter Surgery**," or "**The Perfect Path. Clerk.**" We wish it to be understood that the views of Old Bart's men on either of these crying problems will be very welcome, and even a consultant could qualify for the guinea.

#### HOUSE APPOINTMENTS.

<i>Junior House Physicians—</i>	G. A. Eason.
Dr. Morley Fletcher . . . . .	A. E. Fraser-Smith.
Sir Percival Hartley . . . . .	O. R. Tisdall.
Prof. F. R. Fraser . . . . .	P. E. T. Hancock.
Sir Thomas Horder . . . . .	F. C. Rolca.
Dr. Langdon Brown . . . . .	
<i>Junior House Surgeons—</i>	W. E. Underwood.
Sir Holburt Waring . . . . .	P. Lewick.
Mr. W. McAdam Eccles . . . . .	H. E. Houlton.
Mr. L. Bathe Rawling . . . . .	H. J. Burrows.
Prof. G. E. Gask . . . . .	H. A. Tracey.
Sir C. Gordon-Watson . . . . .	
<i>Intern Midwifery Assistant (Resident)</i>	G. P. Roxburgh.
<i>Intern Midwifery Assistant (Non-Resident)</i>	R. W. Windle.
<i>Extern Midwifery Assistant</i>	(A. R. Macdonald * E. U. H. Pentreath †
<i>H.S. to Throat and Ear Departments</i>	R. H. Bettington.
<i>H.S. to Ophthalmic Department</i>	K. H. Knight.
<i>H.S. to Skin and Venereal Departments</i>	(H. Chilton.* J. Dockray. †
<i>H.S. Orthopaedic Department</i>	E. S. Evans.
<i>Senior Resident Anaesthetist</i>	J. T. Hunter. ‡
<i>Junior Resident Anaesthetists</i>	(J. H. Attwood. N. A. King.
<i>Casualty House Physicians</i>	(C. J. Lavers.* E. S. Curtis.* E. U. H. Pentreath. † S. W. Hardwick. † C. F. Watts. † J. A. Cholmeley. †
<i>Casualty House Surgeon</i>	(D. A. Langhorne.* W. J. H. M. Beattie. †

\* 3 months, November. † 3 months, February. ‡ 12 months.  
All others for 6 months.

#### MANNERS AND CUSTOMS IN GENERAL PRACTICE.

*A Lecture delivered at St. Bartholomew's Hospital on October 19th, 1927.*

GATHER from Prof. Fraser's letter to me, in which he asked if I would address you, that there was a feeling amongst your teachers that ethical questions, especially as touching general practitioners, were not as fully dealt with in your systematic lectures as might be desirable. In consequence the recently qualified men often found themselves launched forth on a strange sea without a compass or a rudder with which to steer themselves, and this led to embarrassments and anxieties, which might have been avoided had they been better informed. It is with the point of view of general practice that my remarks are mainly concerned, though, as I have no doubt that some of you aspire to consulting practice, I venture to hope all of you may derive some help from what I have to say.

It is very interesting to me that I should have been asked to give this address, because some thirty-one years or so ago, in August, 1896, I sent a letter to the St. Bartholomew's JOURNAL suggesting that addresses of this type should be included in the course of lectures. I suggested that "two lectures should be given, one by a consultant, and one by some old and experienced Bart's man in general practice." I had only just started in practice, and felt myself the need of some such help. I little thought then that I should ever be myself giving this lecture. That only serves to illustrate how important it is for the practitioner, even when entering on practice, to look ahead, and be ready to grasp the opportunity that comes before him. You do not know now what life has in store for you. Perhaps you will settle in a practice in the East End of London and end as a specialist in Harley Street; or you may start in suburban practice and end as a medical officer of the Ministry of Health; or you may start in general practice in a country town, do the surgery there, and end as a consulting-surgeon, making a large income in the Metropolis. Yes, it is well at the start to keep an open mind as to the future, to have some ambition, to look ahead ready to seize the golden opportunity when it comes.

Now, in the matter of conduct in general practice, I find myself particularly happy in that I am addressing St. Bartholomew's students, and that because we have a very great tradition behind us. Sir D'Arcy Power, in his book on the Hospital, issued at the time of the

800th anniversary, tells us how, in the Augustinian Monasteries (and you remember that this Hospital was an offshoot from the neighbouring monastery), the Rule for the Master of the Farmery reads—"He ought to be gentle, good-tempered, kind, compassionate to the sick, and willing to gratify their needs with affectionate sympathy." I should like to suggest that that old rule, based as it was on the older and more authoritative saying, "By love serve one another," is the best rule for those entering into general practice; and when one comes to analyse one's conduct as it should be towards our patients and fellow practitioners, we shall find, I think, that it can be summed up by some such words as those I have quoted. From Kahere's time down to the present the idea of service to others, given freely and unstintedly, has prevailed in this Hospital; and it is this idea which you must carry forth with you into general practice. The Bart's man is a "gentle" man; he is one who serves, who carries out with him into the world the old monastic idea of service; you know how still to this day each officer of this institution on his appointment receives his "charge" in a similar way to the brothers and sisters of old, and if, on entering practice, you conceive your charge to be that of the Master of the Farmery, you will have already laid down the principles which will govern your relations to your patients and fellow practitioners.

I will roughly divide up my remarks into separate sections, though these must necessarily slightly overlap, and involve some repetition. Firstly, then, we will consider our relations to our patients, then those to our fellow practitioners, then those to the general public.

I must commence by reminding you that we belong to a profession and not a trade. A tradesman is out for himself in the first instance, and anything which he does for the benefit of the public is always considered from his own point of view first: if it is of advantage to him in his business, it goes; if it is detrimental to his pocket, it does not go. But in the medical profession, while it is necessary for fees to be asked and paid, otherwise we could not live, yet the pecuniary side is not the first thought in the mind of the professional man. You must not, when you are called to your patient, immediately think, "How much can I get out of this job?" or "How long can I keep it going?" That is the way of the tradesman. Your first thought should be "service" again: "How can I help this unfortunate person to get well most quickly and with least expense to himself?" It is ideas of this kind that make us claim our profession especially to be an honourable one, and it is our duty to uphold the honour of it, even if we suffer in so doing. And so you will

not "make visits," as it is said—that is, go on calling upon your patient when there is no need for it, and charging him for the visits. It is one of the difficulties at first of finding out what is expected of the doctor. Different patients view the doctor's visits in different ways. With the less well-to-do patient you will visit exactly when you think it necessary; but, even there (and this applies especially to Panel patients whom you have contracted to attend) you must be careful not to pay too few visits; indeed, where you have no skilled nursing, you must, in many cases, keep a closer watch on the case than when you have a trained watcher keeping guard and ready to warn you of any ill-developments of the disease. I always think that an acute illness with fever, even if it is only the four-day fever of an obvious influenzal catarrh, demands a daily visit. Supposing the patient falls ill on the Sunday night and calls you on the Monday morning: you tell him he has an influenza cold, and prescribe, and say you will call on Wednesday or Thursday. In many cases that might do; but frequently you will find that he is worse on Tuesday: that night he has earache, by Wednesday a membrane tympani bulging, crying out for puncture. If you don't see him till Thursday you are losing the golden opportunity of early puncture and prevention of acute mastoid abscess with all that follows in its train. It is that kind of neglect that gives poor patients a handle against the doctor, such as should never be allowed to occur. So wherever you have to do with an acute illness with fever, visit daily until you can see your way clear to begin diminishing the number of visits.

With the well-to-do patient we have often the opposite state of affairs. In the first place, so far as they are concerned the size of the doctor's bill is of less moment, and when they are ill they want attention and feel aggrieved if they do not get it. With such people it is often wise when you know that a visit twice, say, in a week is quite sufficient, to frankly say, "I will call in four days' time, unless you would like me to come in before." Often you will get the reply, "Yes, please come in to-morrow." That becomes, then, a question of the psychology of the doctor's visit. There is no doubt of the influence for good of mind upon mind, and though you may think you do nothing when you "come in to-morrow," your very presence reassures the patient, and your cheerful countenance brightens them up and doubtless contributes in some mysterious way to the processes of repair. One has constantly to remind oneself that the patient knows nothing about the disease or its progress in the majority of cases; hence we must not be surprised at the fear that is shown sometimes when it is quite unnecessary. You must

try always to put yourself in the place of the ignorant patient, and view the illness from his standpoint; then you will realize what the doctor's visit means. I think, speaking generally, if in the case of the well-to-do patient you endeavour to cut down the number of visits paid, and in the case of the panel patient you pay rather more than are absolutely necessary, you will not go wrong; at any rate let that be the bias in your mind in dealing with this question.

#### THE QUESTION OF FEES TO BE CHARGED.

This is a matter on which it is impossible to lay down rules. You must make inquiries in the neighbourhood where you settle as to what the custom is. Fees generally are some 50% higher than before the war. For a visit for which previously 5s. or 10s. 6d. was asked, now 7s. 6d. or 15s. is taken. For visits paid out of the doctor's round (that is, a "special visit") the patient is charged 50% above the ordinary fee; for a consultation with another practitioner from one to three guineas according to the means of the patient and the time of day or length of the consultation. Midwifery fees are from 2-3 guineas up to 20 guineas, and in some cases an extra fee is asked if forceps or anæsthetic are necessary. I would strongly advise you when you first start in practice not to pitch your fees too high. Everyone in these days knows that the young doctor is very clever, but they also know that he has not the years of experience behind him, and his value at starting is not as great as after he has been five to ten years in practice. At the same time you do not want to undersell your neighbours; and so it is necessary, as I said before, to find out the custom of the place where you settle and consider the matter in the light of what your neighbours do; and further, be very chary of reducing fees without very serious consideration.

The question of "means of the patient" as a standard to determine the fee paid by him is a difficult one. We have no means of ascertaining what a patient is worth—the only guide is the size and character of the establishment which he keeps up, though even in that one will be let down occasionally. It is always wise in any case to write everything up in your books at the ordinary fee, and then, if the illness has been a very expensive one and the patient is not very well off, you can easily put a credit to him of some sum as an allowance, and so reduce the bill. On rare occasions you will find that well-to-do patients will make you, in addition to your fee, a monetary present. Now that is a personal present, and if you are in a partnership, it should be provided in the deed either that such monetary gifts should

go into the partnership deed or that they should not. I think that as it is a personal gift to the partner who has carried the patient through a long illness perhaps, and earned his undying gratitude, such a gift should not go into the common partnership account. However, all people do not think as I do, and providing that it is agreed beforehand and recorded in the deed what is to be done with such windfalls, it does not matter much which way of dealing with them is decided upon. Such windfalls only occur very rarely, and there is no loss of dignity by you if you accept them.

#### EXAMINATION AND TREATMENT OF PATIENTS.

It may be a trite remark to say that when you are called to sick patients you must do something for them. It is rather the fashion now to decry the medicine bottle, but with all due respect to the scientific side of medical practice, I must tell you that you will only too often be obliged to have recourse to empirical treatment of patients. You will frequently exhaust all the means of scientific investigation and analysis, and you will find yourself no wiser than you were by your clinical investigation, and then you will be thrown back on your own resources, and will give this or that bottle of medicine or line of treatment and find your patient the better for it. But if you go on the lines of saying to yourself, "I don't believe in this drug; whatever use can it be? and so I will watch the case," you will cease to do your patients good and they will go off to your neighbour over the way. You must do something for the sick person, and it is up to you to have your treatment armamentarium full of different remedies and methods which you can use. Undoubtedly while you are exhibiting some simple remedy Nature is doing her bit; but don't be so sure, because you cannot give a scientific explanation of the action of a remedy, that it has, therefore, no action at all on the body. Most of the remedies whose physiological action on the human body is known have been in use empirically for long periods, sometimes for centuries, *e. g.* colchicum. So study always to be resourceful, and then you will be the more able to help your fellow creatures.

#### HOW MUCH SHOULD A PATIENT BE TOLD?

In dealing with this question, I should first lay down the rule that absolute truthfulness and straightforwardness in talking with patients is the correct procedure for you to follow. You should never tell a lie to the patients, nor wilfully deceive them. I do not say that it is always necessary to bluntly blurt out, on your first interview, to a frightened woman that she has an inoperable cancer and that her end will come on that

day twelvemonth. That is cruel and foolish; as a fact most patients arrive at the diagnosis or else at the fact that they are doomed without being told in so many words. Some patients like to know the whole truth about their condition; and with them, of course, you must be frank; but I warn you that this type will often endeavour to make you set forth a time-table and tell them exactly when and what is going to happen to them; in such cases, stick rigidly to the facts which you have observed in other cases, and do not be drawn into speculation or dogmatic statements as to the future. The unexpected more often happens than not, and lay folks watching a patient slowly dying will often think he cannot live more than a few hours, when he is quite capable of recovering to a certain extent and going on for weeks. That applies particularly to the end stages of heart and chronic lung cases, though in these, as in other chronic diseases, there is always a chance that something may happen to suddenly terminate the weary life of discomfort, if not of actual suffering.

Then there is another type of patient, who does not wish to be told or to hear anything about her complaint, or to know that the boundary has already been set to his or her existence here. I think this type is more often female than male. Your duty, then, is to acquaint the relatives with the situation, and leave them to do what they think is kindest to the patient; but I always tell the friends that I myself would prefer to be told, for sometimes it is more fear on the part of the relatives that makes them withhold this information than reluctance on the part of the patient, who may be more plucky than she is given credit for. In the case of an individual who has property to dispose of, it is your duty to ascertain from the friends if a will has been made, otherwise grave injustice may be done to the heirs; if it has not, then you should urge the relatives to take the matter in hand, and with decent people there is no difficulty. But I can conceive a situation where there are no friends at all or where the proper people are far away; then a kindly suggestion from you to the patient, made in the course of conversation, that any temporal affairs (and, if you feel able, also spiritual) should be attended to, is the right way to deal with the matter. It is but rarely that you will be called upon like this; but it does happen, and with a modicum of tact on your part the patient will do his duty, comfort his mind and not be unduly alarmed.

#### CONSULTATIONS.

It is your duty, both while you are in Hospital and throughout your career, to do your best by reading, by "talking shop with your doctor friends," by attending medical meetings to keep your knowledge abreast

of the times. The medical profession is, I suppose, more exacting in this respect; also it is more disappointing; because, while you may make all the effort of which you are capable, you cannot possibly have more than a bowing acquaintance with many of the branches of medical knowledge. But you must have that "bowing acquaintance"; and as the new methods, new theories, new treatments come forward, you must endeavour to keep yourself up to date by reading of them. In these days, when we have a press which is clamouring for medical articles, of course, primarily, to sell the paper, and secondarily for the purpose of instructing the public in health matters, you will find that your patients are acquainted with this or that treatment, or have heard of this or that doctor; in consequence, when there is troublesome or prolonged illness, they immediately ask if a specialist should not be called in. Some apparently have an idea that there is a specialist (by which they mean a man who treats nothing else) for every disease under the sun both trivial and serious; and it is not always easy to guide these ignorant people in the way that is best for them. You will find that their friends have told them that a certain doctor is just the man for them, as he is a specialist; when you inquire you may find that he is another general practitioner of less experience than yourself, or even perhaps a quack. Now, people like that require delicate handling. I lay down the rule for you that whenever a patient or his friends begin to talk about specialists, it is a wise thing to encourage them to let you bring in some first-class man, to help you. I am accustomed to tell people that if I feel that I want a second opinion, I shall expect them to let me bring a colleague in, and if they feel they would like it, they have only to give me half a hint and I will arrange it; but, naturally, if they want to go off to irregular or unqualified practitioners, one must say to them that they are at perfect liberty to do as they think right, but that the Medical Acts, *i. e.* the law of the land, prevent you having anything to do with it. You must not take umbrage at the suggestion of a consultation; you may have every confidence in yourself; you may know full well that nothing beyond what you are doing for the patient is likely to help matters; and yet by putting yourself in the place of the patient or friends, you can easily see how they can be comforted by having the further assurance that your methods are backed up by the consultant. Of course, in cases where the diagnosis is not clear and you are in doubt, you yourself will put it plainly to the people, and you will say that you would like a second opinion. You will, if you are wise, suggest two or three names to them, and discuss the matter with them; and as a

result, they will often leave the selection entirely to you. If they suggest someone, it is well to ascertain what they know of him, because it may be merely a matter of hearsay, and their selection may be a most unsuitable man for the case. In this connection do not forget the question of time: if you are in doubt in the morning about the patient you have just seen with a pain over the appendix region, and you do not at a later visit, and being still in doubt, call in help that day, you may be blamed when the funeral takes place the following week. In such a case the friends may think you are fussy, and you may find it hard to persuade them that a second opinion is needed. If that be the case you must be brutally frank with them, and tell them what is at stake. Some people require a sledgehammer to drive it into them.

LEWIS G. GLOVER.

(To be concluded.)

(A full account of Dr. Glover's address to the Abernethian Society will be found in the Society's report in the JOURNAL of April, 1926.—Ed.)

## THE SURGICAL TREATMENT OF MITRAL STENOSIS.\*

**S**INCE Lauder Brunton first suggested the possibility of operative interference in mitral stenosis, attention has, from time to time, been directed to the selection of suitable cases and to the evolution of possible methods. It has been left to Allen and Graham, and to Cutler in America, to evolve routes of approach to this structure. The following remarks are the result of personal communication with them at St. Louis and Cleveland.

The two operations have been perfected upon healthy dogs, and in these animals it has been possible to cut and to clip the valve-cusps. In both cases the convalescence of the animals is rapid and complete, except for the persistence of a valve lesion, subsequently proved by post-mortem. Though it is by no means possible to compare a normal dog with a patient suffering from organic disease of both endo- and myocardium, yet the results obtained shed very valuable light upon the possibility of ultimate solution of the problem.

### OPERATIVE METHODS.

The method of Allen and Graham is briefly as follows: The dog is anaesthetized—respiration being artificial from the moment of opening the chest—and laid upon

\* From a paper by Elliott C. Cutler, M.D., of Cleveland, reprinted from the *Archives of Surgery*, Part II, January, 1926, vol. xxii, pp. 229-242.

its right side. The skin, being shaved and cleaned, is incised, and the left fourth rib is resected for a length of about 3 in. in the anterior axillary region. Should this not give sufficient exposure, the third rib is similarly partially removed.

The lung is packed away from that part of the pericardium under which the left auricle is lying. An incision extending transversely across the axis of the auricular appendix is made about an inch from its tip through the pericardium, and light pressure over the chamber is sufficient to cause the auricular appendix to slip easily through the opening.

A light clamp is then applied at the base of the exposed part of the organ, which is steadied with two sutures and slit along its edge. Into the opening thus made is introduced and ligatured a hollow cylindrical cardioscope bearing a solid glass bull's-eye lens at the further end, and having inside a light and outside a knife, whose blade fits into a slit in the bull's-eye lens. The shaft of the knife lies flat upon the outer surface of the instrument. To cut the valve the knife handle is pushed, the blade being thus lifted out of the slot, then after seeing the cusp in position the handle is pulled, thus clamping the tissue against the glass and cutting it. The smooth surface of the cylindrical shaft enables it to be inserted, to a greater or to a lesser degree, into the auricular chamber. The flexibility of the auricular tissue gives an added factor of mobility.

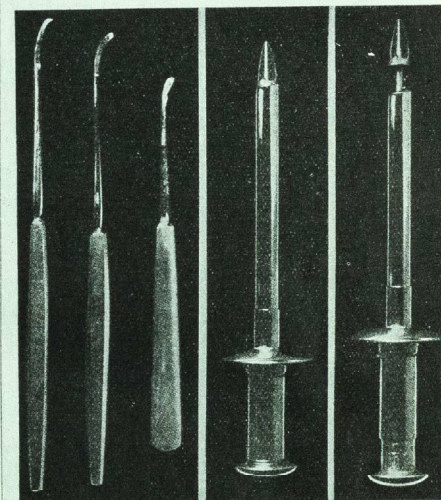
The valve having been cut, the instrument is withdrawn as far as the terminal flange that encircles its tip. The auricular appendix is then again clamped distal to the instrument, ligatured and amputated, and the freed instrument is removed with the small piece of tissue that encircles its head.

The method of Cutler is different from this in most essentials. The path of entry is through the tissue of the apex of the left ventricle, and the operation is a blind one. The instrument at first used was a long-handled knife similar to those used for tenotomy; that employed up to the present is cylindrical in shape, but pointed. The cap can be lifted from or drawn down upon the shaft, which it just fits over, the applied edges of both cap and shaft being knives. This movement is effected and controlled from inside the shaft to the extent shown in the figure. The biting movement enables a considerable mass to be removed from the cusp edges, the instrument, so to speak, swallowing the fragment.

The heart, in the human cases operated upon, was approached and dealt with in the following manner:

The anaesthetic used was ether; the incision was a central one, exposing the lower mass of the sternum

and dividing the upper abdominal wall. The sternum was split and retracted. The pericardium was incised, care being taken to avoid the pleurae, and the diaphragm with its pericardial covering was split for a few inches. The apical region of the heart was then held steady by a ligature passed into it, and two mattress sutures were placed in position around the site of the puncture. After a small preliminary incision the knife was pushed through into the chamber of the left ventricle and the mitral ring reached by feel. The ring was then cut to a greater or less degree.



VALVULOTOMES.

The knife was withdrawn, the mattress sutures tied, and the diaphragm, anterior abdominal wall and chest-wall repaired.

The instrument used in the first three human cases was the long-handled knife, and in the last case the special valvulotome shown in the illustration.

The first case was alive ten months afterwards in apparently improved health; the other three died, the longest survival period being six days.

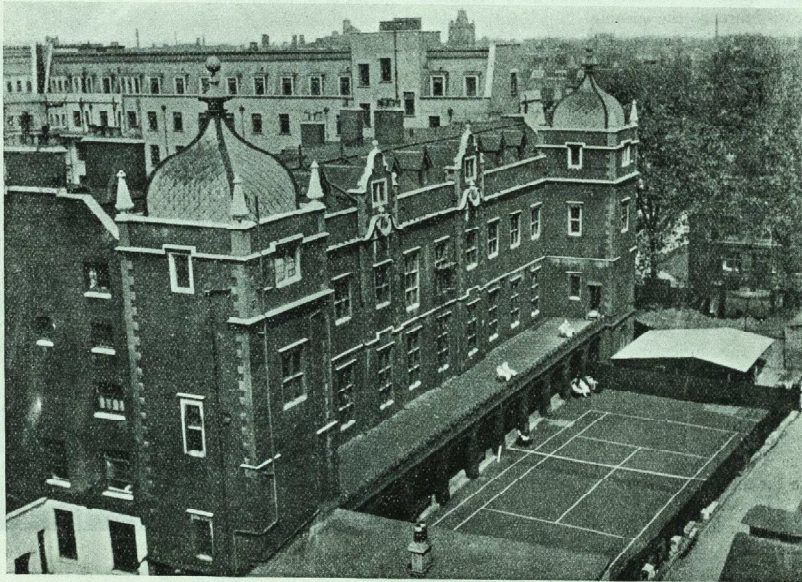
### DISCUSSION.

The two methods vary very greatly, both having their disadvantages. That of Allen necessitates a pneumothorax—a matter of some importance in a condition

where the respiratory tissue is already hampered by congestion; a second danger is the possibility of dislodging from the auricular appendix one of the clots not infrequently present; a third is found in the friability of the auricular wall. On the other hand, the method is not blind; for direct apposition between the thick lens and the endocardium makes it possible to distinguish between the mitral and the valvular endocardium, and to define the position of the latter. Another favourable point is the fact that irregularities of rhythm can be

Even should means of performing the operation without undue risk be perfected, there yet remains the equally difficult task of choosing suitable cases.

The progressive nature of the lesion and the presence of myocardial disease are matters of comparatively minor importance when compared with the judgment of exactly how much of the valve to remove. A large breach suddenly made in a rigid cusp might well expose the pulmonary vascular tissue to hydrostatic changes incompatible with life; on the other hand, too small an



LAST REMAINS OF CHRIST'S HOSPITAL.

initiated in the auricle, even to the extent of fibrillation, without severely prejudicing recovery—a statement that cannot be made of the ventricle.

The route employed by Cutler avoids a pneumothorax, and, in spite of its extent, is one that does the least possible injury to nerves and vessels, thanks to the median incision. The ventricle is less friable than the auricle, and, if carefully handled, will stand trauma comparatively well. When, as seems likely, a means of directing Cutler's operation by vision is employed, his technique appears to be on the whole preferable.

opening would not be worth the trouble and danger of the operation.

It would seem that an extension of the mitral slit at its extremities is preferable to one made laterally into the cusp itself.

In any event the successful experiments upon dogs, and the fact that recovery has followed an operation upon a girl with mitral stenosis, make it likely that operative treatment of suitably selected cases will eventually take its place among therapeutic methods.

GEOFFREY BOURNE.

## TO THE NEW HOUSE SURGEONS.

**P**ERHAPS a few words from one who has been "over the course" and experienced its difficulties and pitfalls might be of some help to those of you who to-day are standing at the start. Inadequate time and space will only allow me to give you a few of the principles that I have learnt through my own failures.

The qualities that make up a good house surgeon are legion. You are now the "front line" of the Hospital, and you will have to deal with many types of people, including patients, nursing staff, relatives, coroners, barristers, policemen, criminals and others, and apart from your professional skill you will need personality, courage and level-headedness in order to uphold the prestige of your position.

You must have equipped yourselves with a most thorough knowledge of the "surgical emergencies," so that even when you are dog-tired your thoughts and actions will come automatically to you along the right lines. You must always strive to cultivate your powers of observation and deduction to the utmost of your ability. These are your surest weapons when you are "up against it," and in situations where book knowledge is of about as much value as froth.

A sound working knowledge of surgical pathology, anatomy and clinical surgery is, of course, essential.

The importance of making a thorough examination of every case cannot be emphasized too greatly. Make up your mind about the case before seeking a second opinion. If you have gone over the physical signs carefully and made your own deductions, stick to your opinion until you find you are wrong.

Mistakes are seldom made through sheer ignorance, but through failure to examine the case thoroughly, and through listening to others.

Do not "snag-shift"; if you do you will lose your self-respect, and you will certainly not gain in popularity with your colleagues. Besides which, "snags" are often most interesting.

See all you possibly can of other men's work.

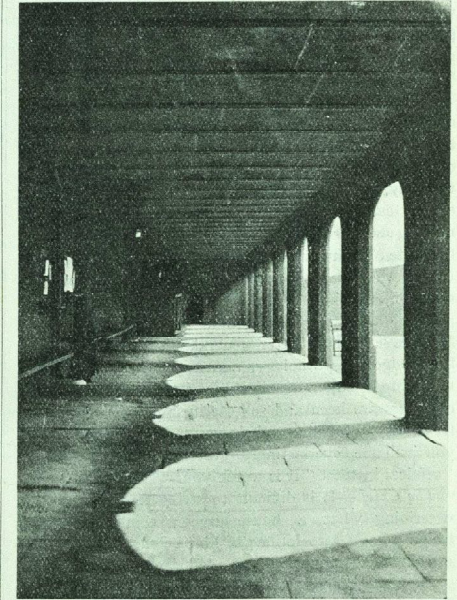
If you have any leisure, employ it profitably in out-of-door exercise. Field games keep one sane, and give one an *esprit de corps* and good fellowship that can only be gained by playing in teams.

Even if it is only getting one's shins hacked in a third team game, do it, for it will give you a *joie de vivre* and a feeling of having done something for the Hospital.

*The patient.*—Never forget that the patient and his welfare is your first and last concern. You are here to serve his interests above everything else. In doing this

you will very often be called upon to sacrifice sleep, food, and much-needed leisure, but do it cheerfully.

Do not treat them only as "cases." It does not take a minute to touch on some human note with each one of them, and for doing this you will be repaid a thousand times by their appreciation and willingness to do as you advise them to do. Find out their jobs, their pleasures, their vices, and make them laugh.



THE CLOISTERS.

Patients require handling in different ways, and you will need a great deal of patience, ingenuity and tact with some of them.

They will always remember you, what you said to them, and how you treated them, and on you depends the impression they have of the Hospital.

Their trustfulness, bravery and courtesy will never be forgotten by anyone who has worked amongst them.

*The nursing staff.*—Under the present system you stand at a disadvantage in having passed through your wards as a dresser, and in having had no practical experience of nursing. For this and other reasons your position is a difficult one.

Realize from the start that you represent your Chief when he is absent from the Hospital, and that the responsibility of the welfare of the patients is *entirely* yours, and that if anything goes wrong you will be the scapegoat. Grip on to these facts and never forget them.

Aim at team-work with the nursing staff. Sometimes in your endeavour towards this goal you may be grossly misunderstood, but stick at it; it is the ideal way of working for the patient. The nursing staff plays a big part in getting the patient well—more often the bigger part. Let them do their share without going over the boundary, and keep your eyes open to learn things. There are several things one would like to see altered in nursing, especially cases of fractured spine and femurs, but if you entertain the idea of getting something changed, do it ever so gradually, and as far as possible tactfully. At times you may have your treatment of a case called into question by some member of the nursing staff; it usually isn't a "pro." This is annoying, but listen to the criticism; one sometimes learns from it. If the critic is reasonable, argue the point in question, but in the majority of cases it is better to preserve a discreet silence and "stick to your guns." You have had a better general education, and your knowledge of pathology, anatomy and physiology is undoubtedly superior. Fortunately for you the majority of sisters are keen and self-sacrificing, tolerant of your freshness, and willing to help you in a manner for which you will be everlastingly grateful. They possess a "clinical instinct" it is worth your while to respect.

*The Chief.*—It is difficult to strike the right note in describing what a house-surgeon thinks about his Chief. One's associations of him belong to that realm of things one cannot express adequately in words.

He plays the greatest part in the whole drama. His work, his manner, his method of dealing with patients and his little idiosyncrasies will live with you into the future.

You will retire feeling proud of having served under such a man.

On looking back one feels that it will have been the richest time of one's life. The courage and fortitude of the sick, the self-sacrifice of those attending them and the companionship of one's colleagues in this great team will leave an everlasting impression on you.

H. B. STALLARD.

## HOSPITAL THOUGHTS.

### REPORT ON THE ESSAYS.

*Competitors preferred rather to paint the Hospital than to analyse the Freshman.*

*True freshers forbore to give their impressions, though shyness might well have taken refuge under a pen-name. A. S. spoilt an otherwise good essay on Freshmen by a wordy striving after epigrammatic conciseness. Of the others, J. W. O. F., the least removed from his fresher days, was too heavy-handed in his criticism of the Hospital. His thesis was the social dullness of St. Bartholomew's, a grey-ness relieved only (here we make a graceful bow) by gleams from the JOURNAL.*

*As a whole, the essays did not climb Parnassus very far, nor did they deviate from the beaten paths of thought or fancy. The guinea is awarded to Mr. Holdsworth, more for his consistency of treatment than content.*

### WHAT THE FRESHMAN THINKS OF THE HOSPITAL.

**T**HE freshman's point of view must depend largely upon which of the two main divisions he belongs to, and into which he must naturally fall. There is the man who has just left school, who comes to St. Bartholomew's to take up, *ab initio*, his medical career; and there is the man who comes down from one of the universities to finish that which he has but half accomplished.

It would not be interesting to attempt to discourse upon what can only be differences of outlook depending upon differences of academic position. Whilst realizing that the man who is entirely new to medicine has far more to impress him than the one who has passed his "second," we shall attempt to deal with impressions common to both, and which are concerned with the Hospital as a whole.

Our hero is lucky in that two of the first people he encounters at St. Bartholomew's are the Dean and Bride. He is lucky because in these two individuals, of widely different positions, there dwells the spirit of "Bart.'s"—the old spirit of "Bart.'s"—which has been with them for forty years and more, and which has been breathed upon, and has inspired the successive generations of men who have gone out into the world carrying that proudest of all medical distinctions—a "Bart.'s man."

The Freshman is immediately impressed with these two of the oldest adherents of the Hospital, and with the devoted service which others, no less than they, have rendered through the years to St. Bartholomew's.

With these, and other things in his mind, he very soon becomes conscious of a feeling of intense pride at the fact that he is a member, however junior, of a very famous, a very old institution, to serve which it shall be his honour and privilege. May it be that those thoughts remain with him during the whole of his Hospital career, and may the spirit of service which he has learnt so soon not abandon him when he goes forth to apply, in his daily work, the principles which he has adopted from his *Alma Mater*.

The man who is quite new to the profession has to bear the shattering, in a very short space of time, of many illusions he has acquired at the outset of his career. He sees things going on around him which are difficult of explanation if the obvious explanation does not suffice. Are, for instance, those rather young-looking fellows who, standing in the "Square," ostentatiously whirling their stethoscopes about, really some of the great physicians of the Hospital? Can those earnest, hurried, strong silent men with white coats, here and there stained with yellow, and with instruments protruding, also ostentatiously, from their pockets, be the surgeons, whose names are household words throughout this great Empire? "How fine, how grand they look," says the freshman. "Shall I ever be like that"—and so on until one day, when he may detect one of them in some more undignified position, and, being both shocked and alarmed, makes more exhaustive inquiries and finds this being called by the less exalted name of "junior dresser!" In quick succession the freshman learns new and more startling facts. He, in his lowly state, is actually permitted to see an operation! Does he ever forget that afternoon? Gazing down upon the scene from the gallery in Theatre "A"—hushed and expectant—his eyes glued on the great man, he watches the silent white figures moving to and fro. The fumes of anæsthetic become more and more pungent—(how do they stick it down there?)—and he waits for the moment of revelation, when the operation proper shall commence. There is some hurried movement, a way is made, and white figures with very obviously shaking hands are preparing instruments. The great man, with scalpel poised, regards with thoughtful concentration the scene of his coming actions, and then with calm deliberation begins that which the Freshman has secretly dreaded—the first incision.

Kindly hands lead our hero from the gallery into the more salubrious atmosphere outside. He revives, is thoroughly ashamed of himself, and bitterly wonders if he can *ever* be a doctor. It is merely that he has encountered one of the first experiences which have come to many a better man before him. It is one of the things he will remember for all time—one of the

things which will help him to form the basis of his mental outlook in the future, because it is a sudden and very definite revelation of the new life into which he has just entered.

The freshman, undoubtedly, is always very surprised at the rather dingy appearance of some of the Hospital quarters. He is conducted to a room, mysteriously termed the "A. R.," and, having made a mental note of its extreme resemblance to a station waiting-room, is informed, with due gravity, that he must, in future, look upon it as his own room of ease and comfort! There he may, in questionable comfort, read all (or nearly all) the current periodicals; may smoke his cigar and throw its ash leisurely upon the unpolished and very wooden floor beneath him, and may gaze upon yet more of the rising young physicians, complete with still whirling stethoscopes.

The hidden hand behind all this splendour belongs to the fairy godmother who is guarding our hero and is looking after his comforts. Her other and more awe-inspiring name is the "Students' Union." He learns much more about this institution later. At present he vaguely wonders who has taken possession of that fifteen or ten guineas (according as to whether he is a "full" or a "university" student) which was extracted from him by force on his arrival. Ignorant youth! He knows not the treasures which are in store for him. He forgets that fairy godmothers step in only when they are most needed. He will soon know all; but now he must be content with the assurance that everything is for the best in the best of possible students' unions.

Far more satisfactory, because it supplies a really pressing need, is the Catering Company. The freshman likes this dwelling, for here, at a small cost, he can procure a satisfactory, if somewhat mysterious meal, served with rapidity and courtesy, and without his having to leave the Hospital precincts. It is to be hoped he will continue to patronize this excellent refectory. First impressions are always the best, and he should remember this if, in future, he is tempted to supply the inner man elsewhere. The only excuse for abandoning it which should be allowed to him, is if he happens to receive the impact of a hard roll of bread upon his head, face or neck. Even then he should not be annoyed. These things will always happen whenever boisterous youth congregates, and he must accept it, not as surprisingly bad manners on the part of those who should know better (as at first he is probably inclined to do), but as a useful piece of evidence in support of Sir Arthur Keith's recent widely-published statements concerning an interesting scientific theory.

The freshman, be he from school or from university, sees, especially in his first few weeks, many things which

perplex him. He comes to the conclusion very early in his career that the Hospital is very ready to help him, while expecting some return, even if in one only of the numerous ways in which he can help. He comes to the conclusion, also, that the Hospital is no respecter of persons. She regards all her freshmen, no matter where they come from or propose to go to, as entirely equal in her estimation. She is out to help and encourage, but the freshman very soon sees that he is, in a sense, far more on his own than ever he was before. He has every opportunity at St. Bartholomew's, both in his work and in his games, to do well that which every person in every walk of life *must* do—to realize his own genius and fulfil his own destiny:

"I am the master of my fate,  
I am the captain of my soul."

W. H.

### "STAYS."

**I**T was one of the few really hot evenings of the year. A tall, rather stout, jolly-looking woman carrying a small child walked into my box in the Surgery. The reason for her visit was the nasty 'acking cough which troubled her infant. I expressed a wish to examine the child, and she proceeded to strip off layer upon layer of clothing. I watched, amazed, in silence, while coats, waistcoats, jumpers, jerseys, shirts and vests were removed in turn from the perspiring child. But when she proceeded to untie a really remarkable garment (the like of which I had never seen before) I could contain myself no longer. I asked what it was. She was surprised at my ignorance. "Don't you know what that is, doctor? That's his little stays," she said. I lectured her on stays; I explained at length how they prevented the child breathing—that they were unhealthy, etc., etc., and finished my tirade by telling her that no one wears stays nowadays.

She went out, I thought, a wiser woman, leaving the door of my box just open. "Do yer know what the young doctor has just told me?" she asked the two rows of waiting patients in her loud Cockney voice. "That no one wears stays nowadays. I wonder 'ow 'e knew that. I suppose 'e's been tickling 'is young woman."  
"Bonzo."

### ANNOTATION.

#### LUNG ABSCESS WITH METASTASES.

J. P., coach-builder, 55, admitted April 13th, 1927, to Brompton Hospital complaining of cough.

*History of present condition.*—In November, 1926, had an attack of lobar pneumonia, but the temperature did not come down. After

nine weeks at home went to Hitchin Hospital. While there the expectation was very offensive, and at one time operation was considered for "abscess of the lung."

*Sputum.*—1. B. negative on repeated occasions.

*Past history.*—Nil of note.

*Symptoms.*—Cough, troublesome at night. *Expectoration* 3½ a day—offensive. "Fishiness" left side of chest. *Hæmoptysis*: Streaky sputum at times (present now). *Dyspnoea.*

*Physical signs.*—Percussion note impaired all over right chest, especially over middle zone at back. Bronchial breathing and whispering pectoriloquy over right scapula. Crepitations heard both bases, and medium moist rales over middle zone right side.

There was intermittent pyrexia, 99°-100°.

26.4.27: *X-ray.*—Restricted movements of right side of diaphragm. Heart and mediastinum to right side.

*Right lung.*—A dense opacity with ill-defined margins in the middle zone, suggesting abscess forming. Pleural involvement.

29.4.27: *X-ray* after lipiodol. Some dilatation of branches of right descending bronchus. Lipiodol had not entered the opacity in the middle zone of the lung.

4.5.27: Antero-posterior stereoscopic and lateral views: "Opacity is in the direction of the interlobar fissure, and is suggestive of interlobar empyema."

*Blood-count.*—Red blood-cells, 4,225,000; white blood-cells, 19,000; hæmoglobin, 75%. The lymphocytosis was chiefly polymorphonuclear.

5.5.27: Chest explored in posterior axillary and scapular lines; nil obtained.

A further exploration in the theatre by Mr. Tudor Edwards also proved fruitless.

The patient continued *in statu quo*, and as the temperature continued to swing, on 25.vi.27 a further attempt at aspiration by Dr. Burrell was made. A slight hæmoptysis followed.

On 25.vi.27 patient complained of pain in the right shin. Two days later a lump was connected with the bone. The next day fluctuation was noticed. At the same time the patient began to get sharp muscular pains and paræsthesia in the left arm and both legs. The grip of the left hand was weak. The leg swelling was aspirated, the pus growing a long-chained streptococcus and a Gram-negative bacillus of the colon group.

6.7.27: The next day the patient had a fit of the epileptiform type.

*Lumbar puncture* was performed, but the cerebro-spinal fluid showed no abnormalities except a slight excess of albumen. The Wassermann reaction was negative; culture was sterile.

The fits continued to get worse and became continuous: there was a purulent discharge from the left eye; the patient was very aphasic. Finally, during the night of 10.7.27, he died of respiratory failure.

The *post-mortem examination* showed a large abscess in the motor area of the right cortex; in the right chest was a large encysted abscess, closely applied to the bodies of the lower thoracic vertebrae, but apparently deep to the pleura and embedded in lung-tissue. No other metastatic abscesses were found.

The occurrence of metastatic abscesses appeared in this case to be directly secondary to the last attempt at aspiration, a vein being punctured (witness the hæmoptysis). The case shows the difficulty of reaching pus when situated in the posterior mediastinum. While everyone was convinced that pus was present, and while incision would probably have saved the man, it was considered unjustifiable where no pus was obtained by the syringe.

### STUDENTS' UNION.

#### RUGBY FOOTBALL CLUB.

##### ST. BARTHOLOMEW'S HOSPITAL v. OLD PAULINES.

On Saturday, September 24th, at Winchmore Hill, the Hospital won, scoring 3 tries (9 pts.) to 2 tries (6 pts.). We were not fully represented, and later on in the season we hope to see Bettington, Gaisford and Lloyd able to play. It was a fine afternoon; the ground was on the soft side, but dry.

Bart's were quickly on the attack, and we were soon treated to a very pretty passing movement. The ball was got out well by Games, and passed *via* Rait-Smith and Petty to Taylor. The latter

cut in to make the most delightful opening, and when confronted by the full back, made a well-timed pass to Grace, who finished off the movement by a determined run down the touch-line to score in the corner. Shortly afterwards Games went over from a scrum on our opponents' line.

In the second half there was another good passing movement, in which Taylor again showed us his ability to make an opening; it was completed by Prowse, who scored in the corner. We were unable to get the ball back after this. The Old Paulines scored two tries at a period when our tackling was weak. Towards the end of the game play became pleasantly vigorous.

It was a very enjoyable game to watch. We were at least a stone lighter per man than our opponents. The captain and vice captain set a good example to the forwards, but the latter were not well together. This cannot be expected in the first game of the season. Our packing in the loose, especially in the second half, was ragged, but some of the work in the open was good. There is an inclination at the end of a dribble, however, to kick the ball too far ahead. The outides made an encouraging beginning. Games and Rait-Smith played well together. Taylor showed us that he has football brains. He made two stylish openings, and what was more, having made them, he passed the ball at the right time—very often the more difficult thing to do. A "dummy" to the full back with the wing man outside unmarked is criminal.

It was an encouraging game, and augurs well for success this season.

##### ST. BARTHOLOMEW'S HOSPITAL v. OLD MILLHILLIANS.

October 1st. The Old Millhillians thoroughly deserved their victory at Winchmore Hill by 2 goals from tries and 3 tries—19 points—to a goal from a try—5 points. The game was played under wretched conditions, rain falling throughout the game and the ball, consequently, being like a piece of soap. In spite of these conditions handling cannot be said to have been impossible, because our opponents handled the ball remarkably well.

We were beaten forward by a heavier pack. With such a light pack as we played it is essential that in the tight scrums all of the eight must push hard. In the loose the forwards brought off many excellent rushes, taking the ball at their feet often fifty yards. Here the rush was generally spoiled by some forward, with more enthusiasm than brains, kicking too hard. On the other hand, the forwards did not deal very creditably with the rushes of their opponents, falling on the ball being conspicuous by its almost complete absence—behind the scrum as well as forward.

Outside the scrum the backs were rarely seen in attack, as none of them were capable of handling the greasy ball. Games was too slow, but certainly had a difficult task and was useful many times in defence. Rait-Smith had a bad day. Taylor was not as good in defence as usual, for though he brought off many good tackles, he frequently upset the entire defence by letting his own man through. We hope he will not be discouraged by the free kick which was given against him. We have no hesitation in saying that such a penalty was grossly unfair, and completely at variance with the spirit of the game. Prowse and Frederick were the only members of the back division who defended consistently well.

Obviously there is room for improvement in the side. We have no doubt that it will improve immensely. There is every indication that we shall have many wet games this season, so the team must learn to handle a greasy ball. It is easy to be pessimistic, but there is no real cause for pessimism here.

Two minutes from the kick-off their left wing scored far out after a brisk passing movement. Our forwards took the ball to their line, but could not score, and they returned. Our backs bought the dummy, and one of their centres scored a good try between the posts. Their third try in the first half was the result of a pass of ours being intercepted. This was converted.

We did better in the second half, although early on Frederick and Grace nearly brought disaster by a bad pass back from the former which the latter fumbled. A nice cross-kick by their left wing nearly resulted in a try. Hume, one of their centres, scored the prettiest try of the day. Starting slowly, he went diagonally towards the left; he then turned quickly in and completely deceived our defence by his sudden change of pace. Their second and last try of this half came as a result of a forward rush. It was converted. Our solitary score came three minutes before the end, Knox scoring as a result of a forward rush. Prowse converted with a good kick.

*Team*: E. V. Frederick (back); A. H. Grace, J. T. Rowe, J. T. C.

Taylor, C. B. Prowse (three-quarters); D. Rait-Smith, J. D. D. Games (halves); R. N. Williams (capt.), C. R. Jenkins, G. D. S. Briggs, H. G. Edwards, J. S. Knox, P. J. Richards, H. D. Robertson, V. C. Thompson (forwards).

##### ST. BARTHOLOMEW'S HOSPITAL v. RICHMOND.

October 8th. In contrast to the previous Saturday, this game, played at Richmond, was played on a fine, sunny afternoon. Richmond had a very strong side out, and easily defeated us by 2 goals from tries, a penalty goal and 4 tries—25 points—to nil. In spite of the large score it was a game. Though there was never any doubt about the result, Richmond always had to work for their tries, with the exception of the last.

We were out-weighted forward, and behind were beaten for pace and skill. Our forwards stuck to their task well, and did far better than could reasonably be expected against their heavy opponents, who, incidentally, were not merely heavy. It may have been that the wing forwards were doing more work in the scrum, but the fact remains that in the open they were not so prominent as usual. T. P. Williams, who was brought in at scrum half, was handicapped by a pack that could not often get the ball. The result was that the backs rarely were given an opportunity to attack. They showed distinct promise when they had their chances, with Guinness back at fly-half to lead them. It was in defence that the back division failed. It is not fair to blame Taylor for all of it, for it must be remembered that he is a full-back trying to play in the centre—a very different position. Again the unfortunate Taylor was up against Aslett, who was in splendid form. Still, the fact is that Taylor was quite incapable of stopping Aslett, with the result that the whole defence was disorganized. The others did their best to stem the tide, but could not contend with the overlap. Gaisford was at full-back again. He found touch beautifully at times with long kicks, but it must be remembered that several did not find their mark, that he was too slow in getting his kick in at times and fumbled badly twice. To return to the forwards, Robinson did very well to hook as often as he did with his pack being pushed off the ball. Scovell we noticed as playing a good hard game, but all must have worked really hard. The tight scrums are not right yet. The front row is not loose enough. They will be better in the loose when R. N. Williams has become accustomed to leading them.

It was with mixed feelings that we saw Maloy playing for Richmond. It was a joy to see him playing in such excellent form, but it was difficult not to wish he was not so useful. He was certainly one of the best forwards on the field on the day. Aslett started the trouble four minutes after the kick-off, when he handed off Taylor and put in his wing, Palmer, for an easy try, which was converted. Richmond were getting the ball far more often than not and attacked continually. We were penalized in our "25" and a goal was kicked. Aslett then made a beautiful opening, cutting straight through and giving Palmer another easy try. The kick failed. Gaisford made a good mark at the feet of their forwards, but we were again penalized for not putting the ball in straight.

Not long after the second half had been in progress Aslett and Palmer scored another try. Palmer received Aslett's pass and returned it almost immediately, Aslett having no difficulty in scoring. Again the kick failed. We began to do better now. We were more in their half than in ours, and were getting the ball more often than before. We attacked for the first time, Guinness working the blind side with Prowse. Ground was made, and Guinness had bad luck to miss the goal with a good drop-kick. In spite of the fact that we were definitely having more of the game, Richmond continued to score. Palmer again scored, the opening coming this time from the other centre. The kick, from in front of the goal, was successful. Our outsidies did more attacking, but the passing was a little wild and not much ground was made. Richmond forwards then took the ball from their "25" to score in a really model dribble. The try was not converted. We replied, dribbled over, but they touched down. In the last few minutes Bunnay, their scrum half, in some inexplicable way ran through almost our entire side to score their last unconverted try.

*Team*: W. F. Gaisford (back); A. H. Grace, G. F. Petty, J. T. C. Taylor, C. B. Prowse (three-quarters); H. W. Guinness, T. P. Williams (halves); R. N. Williams (capt.), C. R. Jenkins, G. D. S. Briggs, H. G. Edwards, J. S. Knox, H. D. Robertson, F. G. Scovell, V. C. Thompson (forwards).

P. G. LEVICK,  
Hon. Treasurer.

## HOCKEY.

## ST. BARTHOLOMEW'S HOSPITAL V. GUY'S HOSPITAL.

We opened our season with a match against Guy's on October 8th on our own ground. The score of 10-1 to us was a distinctly useful start off for the season. Guy's were admittedly fielding a weak side, but we were not at full strength, two men being away in the forward line.

The feature of the game was the reorganization of the forward line at half-time: Hartley was moved to centre-forward, Church took his place at centre-half, while Williams moved out to the left wing. The score itself speaks for the success of this arrangement: at half-time it was 4-0; at the end of the second half it had risen to double figures. In Hartley we believe we have at last found a solution to the problem of our forward line, for he appears not only to be a dangerous shot in our opponents' circle, but a leader for the attack. With a little practice Williams should develop into a useful wing man, and Knight, the freshman on the right wing, showed distinct promise.

The back division should be a source of great strength to the team this year; the robust play of P. M. Wright at left back broke up many an attack by the Guy's forwards.

## ST. BARTHOLOMEW'S HOSPITAL V. BEKENHAM.

October 15th. For three years we have drawn with Beckenham II. This year we went on the field determined to end this state of affairs. Beckenham fielded a strong team, but we thoroughly deserved to win with the score of 3-1 in our favour.

Our back division was again a great source of strength to the side; Hodgkinson in goal distinguished himself by clearing with kicks that would do credit to any "soccer goal-keeper."

The forward line combined together well, but being unused to the three-back play adopted by Beckenham, found scoring rather difficult. The wing men would strengthen the attack if they came in less and centred across more often. The combined system of taking corners worked with great success, Hartley scoring the second goal with a beautiful shot off Williams. The play deteriorated somewhat in the second half, due largely to the cutting up of the ground, which made ball control difficult.

## CORRESPONDENCE.

## SEMI-ERRATUM.

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

DEAR SIR.—There are two of us in this singularly fortunate city. One of us was a student at St. Bartholomew's Hospital during the early days of the war, and the other enjoyed that privilege from October, 1922, until April, 1927.

Well, we both wish it clearly to be understood that on June 1st, 1927, the former got married and the latter did not.

This nuisance must now cease.

Yours sincerely,

GEORGE DAY.  
GEORGE DAY.

Norwich;

October 17th, 1927.

## THE LIBRARY.

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

DEAR SIR.—I wonder whether I might make use of your valuable space to air a little grievance.

We are provided in the Abernethian Room with many interesting papers and periodicals, but one of these—perhaps the most important of them all—has been completely overlooked. *Vincula* is dead, yet out of the ashes has arisen another more worthy journal, *New Troy*. Even if the sale of this periodical should prove too great a task for the Hospital to undertake, surely it is not too much to ask that this chronicle of London University life should find its place among the Hospital literature.

I am, Sir,

Yours faithfully,

J. W. O. FREETH.

The Abernethian Room,

St. Bartholomew's Hospital, E.C. 1;

October 10th, 1927.

## A GOOD ADDRESS.

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

DEAR SIR.—There's nothing like a "good address"—beats Harley Street.  
"Dr. S.—, Genito-urinary Surgeon, has removed to Bible House, 166, Hornby Road (Bombay)."

Yours,

F. E. SWINTON, Lt.-Col.  
(1885-1891).

October 4th, 1927.

## HOPE BURNS ETERNAL.

To the Surgeon

HONOURED SIR.—Please excuse me for writing this note for your perusal. I beg to state that my object in coming here is to have the Noises in my head stopped also to regain my hearing on my right side regained. I beg to state that I have been experimented on for 30 years, & my hearing was almost destroyed by electricity & other mediums

Regularly experimented on began June 30th 1900 at 2 P M

Swelling July 21st 1900

My Ears pierced by Electricity August 15th 1900

I also had some other attacks too bestial to mention

The Experimenting has done no good to me. Took away my hearing also part of my sight besides disfiguring my head

I have Photos that show that I am not like them now—they had no protuberance or ganison as I may be termed

Now dear sir what remedy would you suggest

May I go before a board of Specialists or Aural Surgeons whom I may converse with

I remain

Faithfully Yours

HAROLD HAGGITT

## REVIEWS.

RECENT ADVANCES IN ANATOMY. By H. H. WOOLLARD, M.D. (London: J. & A. Churchill.) Pp. 302. 4 coloured plates and 73 text-figures. Price 12s. 6d.

Last year two of the leaders of British anatomy found occasion to draw public attention to the position of anatomy among British sciences. Prof. Elliot Smith, in the course of his Thomas Vicary Lecture at the Royal College of Surgeons, deemed it necessary to lay considerable emphasis upon the essential value of true anatomical knowledge and research, not only for medical science but for biological science in general, and he appealed to the College to insist on an adequate anatomical education for medical men by means of its examinations. In the Educational Supplement of the *Lancet* Sir Arthur Keith deplored the plight of British anatomists, who, he insinuates, have been robbed of the more interesting and profitable aspects of their subject by the physiologists. It appears that anatomists have tended to wander off on to milluminating side-tracks, so that the term "anatomy" has come to connote something quite different from its real meaning. How this happened is a little obscure. But under the influence of transcendental anatomy, which, in the early part of last century, seems to have been mainly concerned with the search for metaphysical archetypes and the like, the anatomist separated himself more and more widely from the physiologist, and concerned himself with unravelling the details of structure with little reference to function. When Darwin later gave a new perspective to biological sciences by suggesting a rational basis for the evolutionary problem, morphologists were still more stimulated in the same direction, though approaching their problems from a slightly different point of view. Hundreds of them set to work looking for vestiges, homologues, variations and so forth, and, filled with the ardour of a new adventure, they tried to explain every anatomical feature of the human body by reference to supposed ancestral conditions. In many cases these ideas were carried much too far, and even to-day candidates for the primary fellowship are being taught to learn about homologues of muscles and ligaments which certainly cannot exist. It is time for anatomy in England to return to a more sober and scientific frame of mind, and to pay attention to those subjects within its scope which have in many cases been taken over by the physiologist. Many anatomists have realized this for some time, and none more than the author of the

book now under review, Prof. H. H. Woollard. This anatomist is known to his friends as a most enthusiastic exponent of his subject. With a profound knowledge of the literature of anatomical research and with a first-hand knowledge of many laboratories of other countries, Prof. Woollard is well equipped to write a book of this kind. Some may have doubted whether a book on recent advances in anatomy would be a feasible project, as witness the incident noted in the preface of this volume, but this book itself is a sufficient answer to such an idea. All anatomists will welcome it as a brilliant exposition of modern work which is being done by their scientific brethren, and it will serve to illustrate to the scientific world in general that anatomy is anything but a dead subject. As the author indicates in the preface, he selects for treatment those researches which depend rather on the study of living material, and he thus serves to emphasize that anatomists fully realize the fallacies involved in the study of dead and preserved material only. We find in this volume excellent accounts of such subjects as micro-dissection of living cells, tissue culture, vital staining, and experimental embryology. Other chapters dealing with neurological anatomy, the anatomical aspect of ovulation and menstruation, cerebro-spinal fluid, X-ray anatomy, etc., are equally fascinating. Methods and results are set forth with a skillful pen and balanced judgment. To the student who would learn what are the real aims and methods of anatomical science, to the clinician who wishes to acquaint himself with recent anatomical research and the important bearing which it has on clinical subjects, and to biologists in general, this book will appeal as a most valuable and stimulating exposition. Anatomists in particular owe a debt of gratitude to the author.

PHYSICAL SIGNS IN CLINICAL SURGERY. By HAMILTON BAILEY, F.R.C.S. (London: Simpkin & Marshall.) Pp. 217. 261 illustrations. Price 27s.

There is at present, in spite of the almost daily precepts of clinical teachers, a growing tendency to neglect thorough physical examination. Although this fault is not a common one among Bart's men, these demonstrations of physical signs in clinical surgery may be confidently recommended to them.

No special investigations, such as cystoscopy or proctoscopy, which may be necessary to arrive at a correct diagnosis are included, and the author very properly excludes all the modern short cuts to diagnosis, which frequently play too large a part in hospital practice. It is a pity that differential diagnosis is not dealt with more fully in a few instances, but the whole aim of the book is to detail the various methods of physical examination applicable to almost any disease or injury. The illustrations of these are profuse and extremely clear.

The book is a good one, and no obvious errors were encountered. It would form a useful companion volume to the *Case Taking for Dressers* issued by the Hospital authorities. It is not only suitable for the first time dresser, but would be of great value to the senior student or new house surgeon. More candidates fail in the clinical examination of the Colleges for incorrect methods than for incorrect diagnoses.

The cost of the illustrations is no doubt great, but the main criticism of the book is its price—21 shillings.

A MANUAL OF GENERAL MEDICAL PRACTICE. By W. STANLEY SYKES, M.A., M.B., B.Ch.(Cantab.), D.P.H., M.R.C.S., L.R.C.P. (London: H. K. Lewis & Co. Ltd., 1927.) Price 7s. 6d.

To a hospital student in his last years Dr. Sykes's book will read as interestingly as a novel. That is not to say that Dr. Sykes writes fiction, but he deals with a world which is usually a conception and no more to the student. The book has another quality of a good novel: it leaves the reader with a good idea of the world of which it treats, and tells him a good deal without being didactic.

It differentiates clearly between hospital technique in medicine, surgery, midwifery and anaesthetics, and that practicable in a general practice. It indicates pitfalls, and warns the man who would go out in the world prepared to deal with all manner of rarities and finds that half his cases in a year are influenzas! We recommend this book.

THE DIAGNOSIS OF PANCREATIC DISEASE. By ROBERT COOPE. (Oxford University Press, 1927.) Price 5s.

This monograph consists of the substance of the Rogers Prize Essay in the University of London, 1926.

After a brief historical survey and a short discussion of anatomical,

physiological and pathological considerations, the author proceeds to describe the clinical and biochemical methods of investigation of cases of pancreatic disease.

As is perhaps inevitable in dealing with a gland with such complex metabolic associations, at least half of the book is devoted to a careful description of various pathological and biochemical tests of pancreatic insufficiency: though one would infer that in his own practice the author makes use of very few of the cumbersome laboratory investigations which he describes.

He obviously deprecates the multiplicity of the available tests by his reference to the "uncontrolled ingenuity which has so often been applied to pancreatic disease."

A full bibliography is provided. Though rather fuller description of clinical examination would perhaps have increased the value of the work, yet it supplies a critical review of the difficult subject of the diagnosis of pancreatic disease.

LAKE AND PETERS'S DISEASES OF THE EAR. (Baillière, Tindall & Cox, 1927.) Pp. xviii + 310. 4 Plates. Price 12s. 6d.

This book gives a very comprehensive account of the subject of aural surgery.

The illustrations and diagrams are numerous and excellent.

A very full account is given of the clinical methods employed and the deductions to be drawn therefrom—perhaps rather too full for the requirements of the average practitioner.

In the section devoted to otosclerosis sufficient emphasis is not laid on the fact that no operative measures on the ear or naso-pharynx are beneficial or justifiable.

There is an excellent account of aural vertigo, though no mention is made of that vertigo caused by Eustachian obstruction.

On the whole this is a very sound book for those students making a special study of aural surgery.

A. LOGAN TURNER'S DISEASES OF THE NOSE, THROAT AND EAR, 2nd edition. (Bristol: J. Wright & Sons, 1927.) Pp. 234. 12 Plates. Price 20s.

The second edition of this work has been slightly enlarged to include a short description of the operation of dacryocystotomy, while several new illustrations have been added and the chapter on peroral endoscopy extended.

At the same time the book has been kept to a reasonable size.

For its sound and concise treatment of the whole of this speciality it must continue deservedly popular alike with students and practitioners.

OPERATIVE SURGERY DESCRIBED FOR NURSES. By O. STANLEY HILLMAN, M.D., M.S., F.R.C.S., M.R.C.P. (Faber & Gwyer, 1927.) Price 5s.

One of the problems that has to be faced by the writer of a book for nurses is the difficulty of doing justice to his subject and at the same time keeping its cost within reach of those for whom it is intended.

Mr. Stanley Hillman's book can be bought for 5s. 6d. and is admirable as far as it goes, but we feel that an appendix dealing with sterilization and a more comprehensive description of instruments, though it might not come within the limits set by the book-title, would nevertheless have considerably enhanced its educational value.

Blood transfusion is now so widely used in surgical work that we feel it deserves more than a passing reference.

Apart from this the little book is clear, concise and eminently readable, and, moreover, is excellent value for the money.

CUNNINGHAM'S MANUAL OF PRACTICAL ANATOMY. Revised by Prof. ARTHUR ROBINSON. Eighth edition. In three volumes (Oxford University Press: Humphrey Milford.) Price 12s. 6d. per volume.

Another edition of this standard work on Practical Anatomy has just been published. In the main it resembles the last edition, in that the work is divided up into three volumes.

The first is devoted to the limbs, and contains some new diagrams illustrating the extent of the tendon sheaths. These structures may be difficult to define clearly in the cadaver, and are apt to be somewhat summarily dealt with by the dissector, who discovers to his chagrin in the wards that they are indeed very real things.



The second is given up to the dissection of the thorax and abdomen, and it, too, has some additional diagrams.

Whilst the third volume contains an account of the head, neck and brain. All three volumes contain several X-ray photographs which illustrate various points of importance referred to in the text.

The whole "production" of the work is extremely good—the photographs, diagrams and coloured plates being particularly clear, and the directions given on the method of dissection are both definite and accurate.

The only criticism which we venture to make is that the manual is rather lengthy, and gives greater detail than is necessary for the requirements of the ordinary examinations. There is a certain amount of repetition, too, a fairly accurate description of a certain structure being given under the heading of "Dissection," which is followed by a similar but somewhat fuller description given in large print in the following paragraph.

This edition is written throughout in the B.N.A. terminology, but the old terminology names are given in brackets afterwards in most cases where they differ, and each volume contains a glossary of the two terminologies. Prof. Robinson gives four reasons in his preface why he has used the B.N.A. terminology.

This manual of practical anatomy can be confidently recommended to all students of anatomy, and, as of yore, will prove itself to be invaluable to those revising before taking their examinations.

### EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degree has been conferred:  
M.B., B.Ch.—Burrows, H. J.

### APPOINTMENTS.

DACH, F., D.M., B.Ch., appointed R.M.O. to the National Hospital for Diseases of the Heart, Westmoreland Street, W. 1.  
DELLERY, O. H., M.R.C.S., L.R.C.P., appointed House Physician to the Miller General Hospital, Greenwich Road, S.E. 10.  
CHAMBERLAIN, A. G., M.R.C.S., L.R.C.P., appointed Public Vaccinator to the Charnmouth and No. 5 Districts of the Bridport Union.  
POLLETT, Surg.-Comdr. E., R.N., M.R.C.S., L.R.C.P., appointed Tuberculosis Physician (Senior Staff), King Edward VII Welsh National Memorial Association, Medley, Tydvil.  
LOYD, W. ERNEST, M.D., M.R.C.P., appointed Assistant Physician to the Westminster Hospital and Medical Registrar, Drompton Chest Hospital.  
ROBINSON, V. P., M.B., Ch.B., appointed Senior House Surgeon to the Royal Infirmary, Sunderland.  
WALSH, R. A., B.M., B.Ch., M.R.C.P., appointed Assistant Medical Officer to the Whips Cross Hospital, Leytonstone.

### CHANGES OF ADDRESS.

BENNETT, A. H., 7, The Crescent, Selby, Yorks.  
BOLTON, R., Wesleyan Mission, Hankow, Hupeh, China, *via* Siberia.  
CAZALY, W. H., Earl Soham, Framlingham, Suffolk.  
DALE, W. CHALMERS, St. John's Lodge, Warwick Road, New Barnet, Herts. (Tel. Barnet 2065.)  
FOLLIOTT, Surg.-Comdr. E., R.N. (retired), King Edward VII W.N.M.A., 4, Church Street, Merthyr Tydvil.  
HEMMING, J. J., Heath Hayne, Leslie Road, Birchington, Kent.  
HUBBLE, D. V., 105, Kedleston Road, Derby.  
LEWIS, T. C., Ramsay, Huntingdonshire.  
MORTON, J. E. C., Clarendon Lodge, 232, Mitcham Road, S.W. 17.  
NELSON, H. P., 71, East Street, W. 1.  
PIDCOCK, B. H., The Friary, St. Cross Road, Winchester. (Tel. 7.)  
POWELL, J. C., 105, Harley Street, W. 1. (Tel. Langham 2502.)  
SMITH, N. F., Atlantic Hotel, Funchal, Madeira.  
STALLARD, H. B., 34, Carwright Gardens, W.C. 1.  
VINTER, N. S. D., Chippenham House, Monmouth.  
WALKER, H. N., 38, Earl's Court Road, Kensington, W. 8.  
WISE, C. S., 45, Berners Street, W. 1.

### BIRTHS.

ADRIAN.—On October 16th, 1927, at 10, Grange Road, Cambridge, to Hester, wife of E. D. Adrian—twins, a boy and a girl.  
BROCKLEHURST.—On October 18th, 1927, at South Hill Lodge, Canterbury, to Beatrice, wife of Dr. G. L. Brocklehurst—a son.

EVANS.—On October 4th, 1927, at 23, Park Square East, Regent's Park, to Ermine, wife of Geoffrey Evans—a daughter.

KEESE.—On September 22nd, 1927, to Winifred (*née* Davies), wife of Dr. Reginald Keene, Oulton Broad—a son.

KEMP.—On July 1st, 1927, at Wellington, New Zealand, to Dr. and Mrs. Gordon Kemp—a son.

KEYNES.—On October 19th, 1927, to Margaret, wife of Geoffrey Keynes, F.R.C.S., of 10, Boundary Road, N.W. 8, and 1, Park Square West, N.W. 1—a fourth son.

MORLOCK.—On August 19th, 1927, at a nursing home, to Kathleen (*née* O'Neill), wife of H. V. Morlock, M.C., M.D., M.R.C.P.—a daughter.

TELFER.—On September 27th, 1927, to Dr. and Mrs. A. C. D. Telfer, of 18, Howard Road, Walthamstow, London, E. 17—a daughter.

WHARRY.—On September 26th, 1927, at 19, Chester Terrace, Regent's Park, the wife of H. Mortimer Wharry, F.R.C.S.—a son.

### MARRIAGES.

LIOWN—SOLOMON.—On September 15th, 1927, at St. Mary's Parish Church, Swansea, by the Vicar, the Rev. Canon Wilson, W. Ernest, youngest son of Daniel Lloyd, J.P., and Mrs. Lloyd, Swansea, to Olive, youngest daughter of Mr. and Mrs. Sydney Solomon, Swansea.

POOLE—BERRY.—On September 24th, 1927, at St. Cuthbert's, Osborne, Dorset, Jeffrey William, eldest son of Mrs. and the late B. T. Poole, of The Gables, Wistanston, Shropshire, to Phyllis Nina, second daughter of Mr. and Mrs. H. F. Berry, Church Farm, Osborne, Dorset.

WALKER—GILMORE.—On October 15th, 1927, at St. Mary of the Angels, Bayswater, Harry Norman, only son of Dr. and Mrs. Walker, of Tor View, Ipplepen, Newton Abbot, to Mary Madeleine (Maureen), youngest daughter of the late Owen McClarnon Gilmore of Rosetta, Belfast, and of Mrs. M. E. Gilmore, of 88a, Ladbroke Grove, London.

### DEATHS.

BEARN.—On October 18th, 1927, Andrew Russell Bearn, M.D., F.R.C.S., the fourth son of James Bearn, Withington, in his 41st year.

DOCKNS.—On October 2nd, 1927, at Suddon Farm, Wincanton, Newcombe Whitelaw Bourns, M.D., late of 78, Redcliffe Gardens, S.W.

CHIFFERFIELD.—On September 23rd, 1927, at his home, Bangalore, St. Mathia's Avenue, Epsom, THOMAS JOHN Burgoyne Pearce Chipperfield, M.R.C.S., L.R.C.P., in his 72nd year.

HALLOWES.—On October 3rd, 1927, at Elmsdale, Buckland Hill, Maidstone, Adolphus Henry Blackwood Hallowes, M.R.C.S., L.R.C.P., aged 83.

JOULE.—On September 19th, 1927, at Claremont, Dorking, John Samuel Joule, M.D. (Lond.), late of Pinner, Middlesex, formerly of Paddington, aged 77.

NANCE.—On October 2nd, 1927, at Glinton, near Peterborough, after a long illness, Henry Chester Nance, F.R.C.S. (Eng.), son of the late James Nance, F.R.C.S. (Eng.), of Eccleshall, Staffs, aged 71.

### ACKNOWLEDGMENTS.

*British Journal of Nursing*—Bulletin of the New York Academy of Medicine—Giornale dell' Reale Società Italiana d'Igiene—Guy's Hospital Gazette—Kenya Medical Journal—League News of the League of St. Bartholomew's Hospital Nurses—London Hospital Medical Gazette—Long Island Medical Journal—The Medical Review—Middlesex Hospital Journal—The New Trop—The Nursing Times—Post-Graduate Journal—St. Thomas's Hospital Gazette.

### 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, E.C. 1.

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, MR. G. J. WILLANS, M.B.E., B.A., at the Hospital.

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0510.

# St. Bartholomew's Hospital



## JOURNAL.

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

VOL. XXXV. No. 3.]

DECEMBER 1ST, 1927.

PRICE NINEPENCE.

### CALENDAR.

Fri., Dec.	2.—Annual Dance at the Savoy Hotel. 9-15. Dr. Morley Fletcher and Sir Holburt Waring on duty.
Sat., "	3.—Rugby Match v. Plymouth Albion. Home. Hockey Match v. R.N.C. Greenwich. Away.
Mon., "	5.—Special Subject Lecture. Mr. Elmslie.
Tues., "	6.—Sir Percival Hartley and Mr. McAdam Eccles on duty.
Fri., "	9.—Sir Thomas Horder and Mr. L. B. Rawling on duty.
Sat., "	10.—Rugby Match v. Gloucester. Away. Hockey Match v. Royal Navy, Chatham. Home.
Mon., "	12.—Special Subject Lecture. Mr. Scott.
Tues., "	13.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Wed., "	14.—Hockey Match v. Epsom. Home.
Fri., "	16.—Prof. Fraser and Prof. Gask on duty.
Sat., "	17.—Rugby Match v. Mosely. Home.
Tues., "	20.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
<b>Last day for receiving matter for the January issue of the Journal.</b>	
Fri., "	23.—Sir Percival Hartley and Mr. McAdam Eccles on duty.
Tues., "	27.—Sir Thomas Horder and Mr. L. B. Rawling on duty.
Fri., "	30.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.

### EDITORIAL.

WHILE the Hospital stream has flowed on in its unassuming way with little but an eddy here and there to show that it consists in fact of fluid which might be ruffled by nearby breezes, the neighbouring world has been much vexed with gales. Members of Parliament have stormed at each other with the words "We want the organ-grinder, not his monkey."

and then suspended each other. Mr. Noel Coward and (more astonishing still), Mr. Ivor Novello have been booed ostensibly from the pit. The Hospital precincts are so hedged round and protected that we are seldom subjected to the sound of voices raised in tumult, except those of authority. It takes a tough lad to get through an army of porters, dressers, housemen and nurses and then make a row in the wards.

But is it possible that some of this controversial rough stuff is being forced upon that most solemn organ, the JOURNAL? We had ourselves idly noticed that certain of its pages were becoming slightly more argumentative lately, but we gather that its last number met with substantial disapproval in some quarters. Our emissaries have even elicited by whom and on what grounds complaints were made. We bow; but we must add that no one must judge us in this era of loose tongues a chance to give space to contesting pens. We would not (though we might) emulate that snappy daily that publishes an "Open Letter" to celebrities. We have no cartoonist who depicts our leaders in undignified attitudes, dresses them up first as schoolboys and then as navvies, and humorously misinterprets them. No, our criticism of Sacred Tradition is done with the earnestness of the aggrieved. Our pages, we are proud to admit, are open to all intelligent and right-minded reformers whether or not we sympathize with them in detail.

\* \* \*

The Cambridge Graduates held their forty-seventh Dinner on November 23rd, at the Victoria Hotel. The Chairman, Dr. Barris, remarked upon the age of the Club, and modestly suggested that his talents rather than his personality had led the Club to invite him as Chairman at that particular time. There was evidence, perhaps, of an approaching crisis in the slight falling off

in the number of new members, who, however, appeared to make up in quality what they lacked in quantity.

The Club has been enriched by two gifts, a silver snuff-box, presented by Dr. Hugh Thursfield, and a portrait of the Founder. Dr. Barris closed by moulding more firmly into classic form several incidents of his career and of the careers of his disciples. Sir Percival Hartley suavely welcomed the guests. Dr. Thursfield, replying, thanked the Club for removing from Oxford Bart's men their one admissible fault, an innate inferiority complex.

As guests of Dr. Morley Fletcher the Club crowned its formal enjoyments with the more delightful intimacies of Hairy Rouchy's matrimonial agency, ably run by Mr. Vick.

\* \* \*

It is as comforting to one's optimism to bring to light some latent talent as it is to find sulphur-granules in a chronic jaw discharge. No literary body of men will soon be able to keep pace with us in essay-writing without a substantial start. The alternative subjects for next month's essay are:—

**"Surgico-Anæsthetic Rapport,"**

or—

**"The Cultivation of a Conjoint Frame of Mind."**

**ANÆSTHETIC VOMITING.**

**A**LTHOUGH the blessing of unconsciousness is conferred by the anæsthetist, yet oftentimes that sleep has an unpleasant awakening. Vomiting is a condition which we all find particularly unpleasant. It is still more unpleasant when one has a wound in one's abdominal wall, and each retching movement makes one feel convinced that the sutures have parted.

In the present state of our knowledge much can be done to lessen the likelihood of after-sickness; and yet, complete absence of this most distressing condition cannot be guaranteed. The administration of the anæsthetic has a great deal to do with the condition of the patient afterwards, for if badly given the patient may be very uncomfortable indeed. Unfortunately, there is still some unknown factor in the patient's metabolism which influences post-anæsthetic vomiting; for however skillfully the anæsthetic may have been given, some patients will be very sick, and others will not "turn a hair."

*Mechanism of Vomiting.*

Vomiting is essentially a reflex act. The reflex arc may be completed in one of several ways:

1. Olfactory: The mere smell of ether to a patient who has been anæsthetized with it previously is often sufficient to cause retching. A method of obviating this "reminiscence" is to place a towel soaked in vinegar over the patient's mouth at the close of the operation. This lessens the likelihood of vomiting by removing the taste of ether.

2. Central: In cerebral conditions vomiting is produced by direct stimulation of the centre.

3. Pharyngeal: Sometimes the mere insertion of a dental prop near the soft palate is sufficient to cause unpleasant retching. If a patient be too lightly anæsthetized the insertion of an air-way will cause vomiting.

4. Gastric: Another very prominent cause of vomiting is an acute gastritis caused by the swallowing of ether-laden saliva.

5. Hepatic: In many diseases and disorders of the liver vomiting is a prominent symptom. In arsenic, phosphorous chloroform poisoning and acute yellow atrophy, etc., vomiting is a usual symptom. According to Gwathmey, both chloroform and ether cause some fatty degeneration of the liver. It is possible that much of the persistent vomiting after anæsthesia is due to this liver damage. It ill becomes one whose knowledge of bio-chemistry is very limited to make statements with regard to this great branch of medicine, yet I think that much of the vomiting originates from liver upset. It is well known that a liver well charged with glycogen is less likely to be damaged than one which has been starved.

In illustration of this the following case is reported: A little girl, æt. 10, was given an anæsthetic of chloroform for twenty minutes, the operation being for hernia. At that time Mr. Brims and I were examining blood-sugars together. This child was prepared for operation in the usual manner; the anæsthetic went apparently perfectly. Soon after coming round she began to vomit. This continued for over twelve hours, her face became flushed and her lips dry, and there was a suggestion of a yellow tinge in her sclerotics. The blood-sugar results showed a very low reading prior to operation: it was 0.03 mgrm. per c.mm. During anæsthesia it rose to 0.14 mgrm. per c.mm., showing a gradual fall afterwards as the anæsthetic was withdrawn. Fortunately the child recovered with treatment.

*Pre-operative Treatment.*

We no longer starve and purge our patients unmercifully. Glucose, in the form of barley-sugar, is recommended to be given by mouth during the day previous

and up to two hours before operation. If the patient does not like barley-sugar, very sweet lemonade may be substituted. The body puts up a better fight against surgical shock when well nourished, and there is less likelihood of a ketosis afterwards.

If the patient be nervous, morphine combined with hyoscine is of great help before operation. Morphine, if true, occasionally causes nausea. Atropine, by preventing salivation, is also most useful. A very satisfactory preparation is "hyoscine compound A," B. W. & Co. This contains—

Morphine . . . . .	gr. ½.
Hyoscine . . . . .	gr. ⅓ <sup>00</sup> .
Atropine . . . . .	gr. ⅓ <sup>00</sup> .

*Choice of Anæsthetic.*

One should attempt to choose the anæsthetic appropriate to the type of operation to be performed. If abdominal relaxation is not required, plain gas-oxygen with no added ether or chloroform is almost the ideal anæsthetic, for there is no unpleasant after-taste, and the patient is round almost immediately. For this type of anæsthesia, morphine and hyoscine are almost essential, and the dose for an average adult should be morphine gr. ¼ with hyoscine gr. ⅓<sup>00</sup> one hour before operation, followed by a further injection of morphine gr. ½ fifteen minutes before operation. Even after plain gas-oxygen there is sometimes vomiting.

On the other hand, if full muscular relaxation is necessary then ether or chloroform must be used. Ether will often cause much vomiting, because the after-taste is so unpleasant. If a patient has had an anæsthetic of ether previously, and has been sick after that administration, then the taste of ether after a subsequent anæsthetic will be quite sufficient to make that patient very sick indeed. This is where vinegar is so useful. It must be emphasized that a towel well soaked in vinegar be kept over the patient's nose and mouth until consciousness supervenes, so that the taste of ether be reduced to a minimum.

Much controversy has raged round the subject of chloroform. Properly used it is a most safe and satisfactory anæsthetic. It is contra-indicated for children, in all severe toxic states, and in acute septic abdominal conditions. Where chloroform is to be used, glucose should invariably be given before operation.

*Induction.*

A smooth induction means a placid anæsthesia. Whether the induction be rapid or slow does not seem to matter from the point of view of after-sickness, provided that swallowing and salivation be prevented.

Undue "crowding" of the anæsthetic agent is responsible for salivation, and for the resulting sickness in some cases, caused by the swallowing of ether-laden mucus.

The use of gas or gas-oxygen at the commencement of anæsthesia is strongly recommended, as the patient is walled into unconsciousness in the most comfortable manner possible.

*Ketosis (sometimes called "Acidosis" in error).*

Occasionally patients get this condition after an anæsthetic. Some observers state that almost 70% of patients pass acetone bodies in the urine after operation, and other observers give smaller figures. When this condition occurs vomiting is often intractable. Thalhimer and Claudia Potter in America, and others, have been using glucose and insulin for the treatment of this distressing condition. They report some great successes. One of my patients had been vomiting for two or three days, and was suffering from a ketosis. She was given 200 c.c. of 10% glucose intravenously, together with 10 units of insulin subcutaneously. Vomiting occurred once or twice after this during the following twelve hours, and then the dose of glucose and insulin was repeated. After this second injection vomiting ceased completely and the acetone bodies disappeared from the urine.

I have treated a few cases with insulin and glucose during the operation. Of six cases the first five (all abdominal) did not vomit at all, but the sixth was very sick indeed. The patient was very fat and the operation was for gall-stones. It would appear from these few cases that the injection of insulin and glucose is very useful in some cases, but is not a specific.

*Phosphates.*

Bourne and Stehle have shown that there is a large output of phosphates in the urine during the twenty-four hours after operation. This output may be ten times the normal. During the anæsthesia very little phosphate seems to be excreted. These observers show results which tend to prove that phosphates given *per rectum* after anæsthesia diminish the vomiting. I have had no experience of this yet.

*Type of Patient.*

The frame of mind of the patient has much to do with the after-result. One who is very nervous is liable to be sick. "Suggestion" in the hands of the late

Dr. Wilson, of Manchester, was very useful in the prevention of after-sickness.

#### Treatment of Anaesthetic Vomiting.

The patient should be put back into bed, lying on the right side if possible. This enables the stomach to empty its contents into the duodenum more easily. As soon as the patient has recovered consciousness the sitting position should be assumed, and a "donkey," (*i. e.* a bolster arranged transversely and tied at each end to the head of the bed) should be placed under the thighs so as to maintain the sitting posture. It is much less distressing to be sick in this position than when lying flat on the back.

Flatulence should be prevented as far as possible by the injection of pituitrin 0.5 c.c. together with eserine gr.  $\frac{1}{100}$  six-hourly, and by the giving of a turpentine enema. If the patient has been given morphine the enemata may be retained.

Sodium bicarbonate, dr.  $\frac{1}{2}$  in a tumbler of hot water, if drunk down completely, will often stop vomiting. The large amount of warm water with sodium bicarbonate washes the stomach free of the ether-laden mucus. The patient usually vomits the tumberful almost at once, and a repetition of the dose will often stop the sickness completely. Too much sodium bicarbonate, however, may cause alkalosis and aggravate the sickness. If vomiting persists in spite of this, iodine in 1-minim doses in a wine-glass of water may be tried. Ice, to suck, has also produced good results.

Chlorodine (tinct. chloroformi et morphinae co.) has been recommended in doses of 5 minims every half hour. I have not tried this yet.

Should vomiting prove intractable morphine should be given, and the patient encouraged to sleep if possible. Once sleep has supervened the patient usually wakes up relieved of nausea.

Cocaine, gr.  $\frac{1}{10}$ , given in a little milk and repeated in half an hour, sometimes will cut short an attack of vomiting.

Champagne is another remedy much recommended. If it be used, let the bottle be iced well, and let the wine be very dry and not at all sweet. It should be served in a dainty glass, so as to appeal to the patient as much as possible. When one is ill one's palate is very contrary, and what would be drunk with appreciation normally is thought to taste rather curious after an anaesthetic. But if the wine be icy-cold it is doubly welcome, and the derangement of taste is not so noticeable.

As a last resort gastric lavage is to be tried, and the insulin-glucose therapy undertaken, as recommended above.

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FRANKIS T. EVANS.

## MANNERS AND CUSTOMS IN GENERAL PRACTICE.

*A Lecture delivered at St. Bartholomew's Hospital on October 19th, 1927.*

(Concluded from p. 22.)

For my part, I always welcome consultations for more reasons than one. The patient and the friends are encouraged by the feeling that they are doing all that can be done; it is an opportunity to me to talk over the difficulties of the case with another; and you must remember that those difficulties are not seldom entirely remote from the disease from which the patient suffers. Often enough it is the family affairs or disagreements or what not that are as much trouble as the patient's complaint; and you will find, as the family doctor, that you will have to bear the burden of some of these as well as treat the complaints. I have often thought that had I naught else to do than to treat the physical ailments from which people suffer, half the worries of general practice would be non-existent. It is often in this matter that a tactful physician or surgeon can be of such great help to the general practitioner. May I beg of those of you who aspire to being consultants to cultivate and practise the art of tactful talk for patients? For you to come out into consultation with no equipment beyond the latest bacteriological stunt, or theory of treatment, or latest sample of German drug, and to sit mum in front of the patient, is not going to

help very much, though I confess it is profoundly interesting to me as the general practitioner; and (in parenthesis) I may add here that it would be difficult for me to appraise the great value to me of the talks I have had with my friends at consultations; I have learnt things from them which have been of the greatest value to me. You must learn how to talk to the patients and their friends; the psychical effect of that, quite apart from the purely medical treatment, is of the very greatest value. That mind has an effect on matter is obvious to any examinee who has suffered from diarrhoea nervosa or actor from stage fright; and so in the same way the consultant's sensible explanatory talk to the patient and the friends is of the greatest help to them and to the general practitioner. This should be given after he has discussed the lines of treatment with you. When you have a consultation, remember you are in a sense the host; your physician is an entire stranger, probably, where you are an old and trusted friend. Therefore when he comes in, it is your duty to put him at his ease with the friends and patient. You will be at the house before he arrives, so as to receive him; and you will not forget to introduce him to the people who are in the room when he is received. Then, after you have finished with the weather and the usual comments on the punctuality of doctors in keeping appointments, you will suggest to the friends that you would like to tell the physician about the case; and they will then discreetly retire to inform the patient upstairs that you will be up in a few minutes. You will have in front of you the temperature chart, properly kept by the nurse (*e. g.* in a case of acute pneumonia) with her report-book, in which she will have noted amongst other things the total input of fluid and output of urine (this is a most difficult thing to get nurses to do, but I always think it is a great help); then your prescriptions should be pinned together in order of date to the cover of the note-book. Thus you will be able, in conjunction with what you tell him, to place concisely in front of the consultant all that is known of the illness, and its treatment up to date. You will then lead him upstairs and introduce him to the patient; and do not let him, if you can help it, diagnose and discuss the case before he sees the patient, as it only wastes time; he has to do it again after seeing him. In the bedroom the physician is in charge, but you can often assist by seeing that things are made comfortable for his examination. Maybe he hesitates to sit the patient up when you know that it is quite safe to do so, or to have the abdomen uncovered, which the nurse, of course, should do for him. Do not forget that it is often more convenient to get a rectal examination done by the consultant than

to do it yourself. It may be resisted when you offer to do it, and will be acquiesced in when the consultant does. You then, if the nurse has not done so (and you have not always a nurse at hand), offer the physician a clean towel to wash his hands; and when he has gratefully thanked you, he will lead you downstairs to the room to talk over the case. When you have finished your consultation, you call in the relatives and he explains things to them; if there is any difference of opinion as to diagnosis, he can quite well put it to them in some semi-humorous way and time will show which is right. Of course, if the difference is really a serious one, involving the line of treatment, *e. g.* a surgical operation, it may be necessary to suggest a third opinion. I would again warn you not to take umbrage or to let your *amour propre* be disturbed by the suggestion of a consultation on the part of the patient. You have nothing to complain about; if people choose to spend their money in fees to consultants, and yourself, who are you to hinder it? You can kindly say that you don't think it necessary at the present stage of the case, but will gladly welcome it if they wish it. There is one other point in this connection. I have said you are the host of the consulting physician or surgeon; therefore you must look after his comfort. He will be very uncomfortable if you let him go away without his fee. His business is done on the C.O.D. system, and it is your duty to see that the patient's friends are acquainted with the amount of fee and that they have the money ready. In the case of women, I generally offer to give it to the physician for them, as they are often embarrassed by these matters; the business men usually look after it themselves. If you do not know the proper fee, the consultant will tell you; and, like ours, their fees also have been increased in amount since 1914.

Now we pass on to your relations to your fellow practitioners; and this involves a few words about settling in practice.

As you are aware, you can either sit down behind your plate and wait for patients to come to you, or you can buy a practice, or a partnership; you may also commence by going as an assistant for a time. If you do this last, you must bear in mind that you will be prevented by deed from practising in the near neighbourhood and for several miles around for a very long period afterwards; if this were not provided against, a man might go as assistant, and immediately after leaving settle down in opposition and take the patients. It is in the country, perhaps, more than in town that these restrictions are so important. In the country there are a limited number of doctors, spread over a circular area of, maybe 30 miles in diameter;

double the number of doctors, and the living, more or less comfortable, which they have been able to obtain is reduced to much smaller proportions. Thus it is important that, if you settle in the country, you should take over a partnership or otherwise a pre-existing business, and not attempt to squat behind your plate. In London and big cities his does not apply, as there is room for all.

However or wherever you settle in practice, your first duty is to call upon your fellow practitioners and make their acquaintance. In London and big cities you will confine that to the men nearest to you, and to those most prominent in the medical activities of the district and to the senior men. I should recommend you to include in these the chairman and secretary of the local Division of the British Medical Association. In the country districts you will call on all those in your town; probably these will be only four or five in all. The reason for this is that from time to time you will require help yourself or have to give it to others, and it is desirable that you should know and be known before the occurrence arises. Acquaintance thus begun may not go very much further; your relations may remain those of acquaintanceship, or may progress to those of friendship; but see to it that nothing is done by you to upset the friendly relations that should subsist between neighbouring medical men. I fear that in London, and possibly in the big cities, this time-honoured custom of newcomers calling upon the older practitioners is becoming more and more honoured in its breach than in its observance. You will hear young practitioners say, "I called on a dozen men when I started and only two returned my call; what is the good of it?" I do not defend the discourtesy of those who do not return the call; there is no excuse for not stopping on one's round and leaving a card, so as to acknowledge the newcomer's visit. I fear that as you go on you will find the world is made up of all sorts, and that there are those in the profession who have mistaken their vocation, and who would have been more suitably employed in other walks of life. But what I want to impress upon you is that it is your duty to say nothing of its being to your advantage to uphold, as St. Bartholomew's men, these laudable customs, even if you find men from other schools have no manners themselves and cannot appreciate your good breeding. You never know how much depends upon these little courtesies and niceties of life. I warned you about looking ahead when you start; you will find as life goes on that from time to time, if you are a courteous, well-spoken-of man, who keeps himself up to date, patients begin recommending others to consult you, or doctors in different towns advising their old patients

who settle in your neighbourhood to have you as their family doctor. But you may take it from me that if, on settling, you behave badly to your fellow practitioners and roughly to your patients, it will tell against you all through. One of the most frequent occupations of the young general practitioner, especially in big cities, is to act for his neighbours in their absence. When you are called to a patient who is a total stranger to you, it is necessary, if it is an emergency case (and in other cases it is wiser), to ascertain at once if they have sent for "their own" doctor. It is your duty to protect his interests under such circumstances; to act until he comes upon the scene, and then to retire, handing over the future conduct of the case to him. You must not take advantage of a sudden emergency to say, "This is a new illness, and I am called in; I shall keep the patient." If you do that your colleague will accuse you of grabbing his patient. Of course, it is often an easy thing to do. The patient's friends send for the first man in the emergency, and perhaps they have not that sense of loyalty to their doctor which you find in the constituents of good family practice; or they are too shy to tell you who is their usual medical attendant; and thus it comes that you have at once the safeguarding of the interests of your fellow practitioner. You may even be urged to carry on the case, but do not do it, except, of course, at the direct request of the regular medical man. If they have no regular medical attendant, of course you are free to continue with the case. It is far better, from every point of view, for you to keep on the best terms with your medical neighbour than to acquire by accident his patients; and you may console yourself with the reflection that patients so disloyal to their own medical man are rarely found to be a source of stability to a practice. When a patient wishes to transfer from one doctor to another it is quite a simple thing, and there should be no ill-feeling between doctors about it. "Free choice of doctor" is a slogan in connection with National Insurance matters, and it is pre-eminently the right of every patient in every walk in life. All he has to do is to write a courteous letter to his former doctor to ask for and to pay his account. When you take over the patient you will ask him if he has let his former doctor know, and that doctor should write to you and tell you any medical details about the patient's case, so that information acquired, for which the patient has paid (e.g. X-rays, biochemical investigations, etc.), and are, in a sense, his property, are handed over to you in taking over the case; if this does not happen it falls to you to let the out-going doctor know you have been called in. Now that is the procedure which you, always bearing in mind first the interests of the patient,

second, those of your colleagues, and lastly of your own, will follow, because you know it to be the best thing for everyone concerned. But I am bound to tell you that you will only too often find other doctors will not treat the matter in this way; none the less pitch your ideal of conduct at the top and strive all through to attain to it.

#### HOLIDAY WORK.

The young practitioner will often be asked to act as *locum* for his neighbours during holiday time. In the towns, in general practice, I think the usual custom is for the *locum* to be paid half the fees which he has earned for the absentee. It is no small advantage for a young doctor to do work of this sort; his name gets known in the neighbourhood, and he gains his experience of managing patients in another practice than his own, so that his mistakes, if he makes any, do not fall so heavily upon him. You must, of course, be more than particular in looking after the interests of your friend on holiday; you must be careful to avoid saying anything in criticism of him which might lead to the undermining of the patient's confidence in him. You may not agree with his methods of treatment of this or that case, but you will be wise before revising his methods to be quite certain in your own mind that those you propose to adopt will be better in every way for the patient; as soon as he returns you hand over all the patients to him and retire gracefully. It is his first duty, on his return, to receive from you a list of the visits you have paid for him, to price out the amount of fees booked against the patients, and forthwith to send you a cheque for half the amount. I have omitted to say that any fees you take in cash from or in connection with his practice belong to him, and are to be handed over by you. I believe some principals have been accustomed to delay paying their *locums* until the patients pay the bills. That, to my mind, is altogether wrong. The principal should stand the racket of the bad debts, and it is not fair to ask the *locum* to do so.

You will find that you are often tempted by the patient to see a case through to the end, even though their own doctor has come back; you must on no account agree to do so; if you do, that will destroy your chance of acting as *locum* in future for that man. The only occasion on which you can do so is if the principal himself, knowing all the circumstances, requests you to continue. Occasionally it happens that the patient has already made up his mind to change his doctor, and if you throw up the case on the doctor's return will call in a third man. That is a very awkward position for you; but if your principal is a sensible man he will

immediately say to you, "Go on with that patient. I would rather, if he will not have me, that you, who have helped me and are my friend, should retain him, than that he should go to a stranger." I always think that where a medical man is sick and another is called upon to do his work that work should gladly be done without payment. The direct expense of illness and the loss through not being able to look after his practice is a heavy handicap to a medical man, and it is a burden which may fall on any of us at any time; therefore we should each "bear one another's burden" gladly on this occasion. It may be you are acting thus and the principal dies, leaving a widow and family. You are then, as a rival practitioner, immediately faced with this problem: Is it best for you to buy the death vacancy in the ordinary way, or to facilitate the introduction to that practice of an entire stranger to the district. If you decide upon the latter course, which is the most difficult from your own point of view, it is your duty to help the widow in every way you can to introduce the new man to the patients; and you must do your best to induce the patients to give the newcomer a trial. The position is admittedly a very awkward one; because when a man dies the patients feel at a loose end and perfectly free to call in whom they like; and in like manner, the other doctors in the neighbourhood usually consider themselves free to accept the patients of the deceased without further inquiry or ado. The only advice I can give is for you to think of the widow and her interests first before your own, and to use all the tact of which you are possessed in dealing with the matter.

I would like here to caution you about discussing your neighbours with the patients. The latter are quite ready to gossip about the doctors and other patients; your lips must be sealed, and whatever you may hear about doctors or patients, say nothing either for or against. I always rather enjoy, on the rare occasions when it has happened, when Mrs. Jones meets me in the street and says, "Doctor, what is the matter with Mrs. Brown?" absolutely smothering the inquiry. You will be surprised what direct questions are sometimes put to you.

#### GENERAL PUBLIC.

I should like to say a few words about your relations to the public at large. You are citizens and rate-payers in the borough or county wherein you settle; also you are educated men; therefore it is a right and proper thing for those who can do so to take an interest in public affairs. Moreover, if you take your share in them, it gives you an opportunity of

helping in the education of the public in health matters. Representation by you of your fellow citizens upon the local authority is a duty that may come to you later on, and I urge you to accept it, should it come your way. To be on your local Public Health Committee is an interesting side-line to general practice, and gives you the direct opportunity of backing up the medical officer of health in his efforts to secure the well-being of your fellow citizens. In these days, when so much is done for the community at large and paid for out of the rates and taxes (not infrequently to the detriment of the pocket of the general practitioner), it behoves the medical profession to play its part rather more actively than it has done in the past by serving on these committees and councils. It is only by the continued education and guidance of the public that a stand will be made against the impudent quackery that has become so rife amongst us of late years; and while you must keep an open mind for all new lines of thought, you must use your judgment and your experience to the full, and put it at the disposal of your fellow citizens on every opportune occasion.

### BRIGHTER SURGERY.

*The essays submitted this month were of a gratifyingly high standard, and we regret that our means and space do not permit more generous treatment of those "of you boys who have not won prizes this term." Particularly do we commend F. A. He would brighten surgery chiefly with pints of the milk of human kindness—a beverage he considers can be conveniently imbibed by both sexes. His "Perfect Path. Clerk" would warm the heart of a Cohnheim, but the father of asepsis might wring a ghostly hand over kissing in a theatre.*

*The prize is awarded to F. W. F. W. May we say how touched we were by the neat little ribbon bow adorning his manuscript?*

**M**ONOTONY must be inevitable in all things where great variation is not possible. Surgery is no exception. Advances in technique, Sir Berkeley Moynihan would have us believe, are not likely to be many, as already a very high standard has been reached. Diagnosis is also unpromising, and brightness can only be attained in surgery, as in everything else—by variation.

Colour offers unending opportunities for originality: but more than this is necessary, and colour, rhyme and rhythm is the only cure. Who of us has not been soothed to sleep on a hot summer afternoon's round by the monotonous voice of a dresser, reading the usual note,

in indifferent English, and using those time-worn phrases, every one of which is as well known to us as the alphabet? It certainly is fascinating to read—"Eyes: pupils equal; react to light and accommodation" for the first time, but even the most enthusiastic dresser finds it ere long an unimpressive introduction to his story, and reads it out shamefacedly and hurriedly, as if it tasted unpleasantly in his mouth.

Furthermore, as an ex-dresser I complain that I was not allowed to express my own views sufficiently in my notes—they might have caused a flicker of mirth at least on the faces of the listeners, and to arouse a smile (according to a recent advertisement which I read the other day in the Mansion House train) is contributing something to our duty in life. "Thou shalt not make a diagnosis" was a battle-cry which even now I hear in my dreams, and I break into a cold sweat as adrenalin pours out from my suprarenals, and instinctively lick my lips for the suitable excuse which I have never yet found.

Let us have, then, music everywhere, in wards and theatres. The literary dresser will have full scope for his art, the musician fresh fields in which to prove his mettle, and the result will be a Littero-Chirurgical Renaissance such as has never been since Hippocrates was appointed the Roman equivalent of Casualty H.S. In our notes, variations in metre will draw attention to vital points. Those surgeons who are modern enough will no doubt demand a high standard of *vers libre*. Fortunately, many can turn to the poets for a pattern. Let the Chief, whose baritone voice is only heard at its best when raised in abuse at the abortive efforts of his dresser to thread a needle, cultivate a habit of song.

Imagine, therefore, it is about 1.30 p.m., and the Chief finds his dressers in the Square attired in loud checks, deep and shiny collars, wide bow ties, and flat-topped bowler hats; all wear waistcoats of the traditional colour of the firm—yellow, pink and so on. The surgeon, of course, can dress less strictly (his dignity is already well-established), and in hot weather that would be more impressive than to see him descend from his car and advance through the archway attired (*à la Lido*) in loosely-fitting well-striped pyjamas, with a sunshade if necessary, the colour scheme again embodying his firm's colour?

Throwing open the ward door where the sister and nurses are arrayed for the round in their evening gowns, he says—not "Good afternoon, sister"; Heavens, no! Not that prosaic greeting. In a full-throated voice he sings—

"I paced by your window, though no one was near,  
Good night and good morning—etc."

Now I have heard a surgeon call the roll, and with a

wrathful mien sternly ask for the absent ones. This is surely a wrong spirit, and casts an immediate cloud on the company; far better is it to rejoice with those who *are* present, and so the surgeon here with a beaming eye mingles his *basso profundo* with the transitional tones of his dressers, the treble of the probationers, the soprano of the stripes, the contralto of the Belt and the falsetto of the sister as they all chant "The more we are together." Then the business begins. The dresser in a pleasing tenor sings—

"I have a note to read-o."  
Chief: "Read me your note-o."  
Dresser: "Oh! I must tell of a nervous youth,  
With greasy skin and a curious tooth,  
And septic tonsils too forsooth,  
It's exophthalmic goitre."

A clinical picture in verse is a fascinating ideal; and the dolor, rubor, calor, tumor of Hippocrates is an early, and to my mind a poor effort. After all, Latin is an easy language for rhyme; make every word end in -orum or -issimus and there you are. But to return. It is seldom that our female beds are occupied by patients of great beauty, but it does happen, and what is made of it? Nothing. Who, years, after reading the note, would dream that the owner of that lipoma was a vision of ravishing loveliness such as seldom delights the eye of man nowadays? Let us make our notes miniature portraits in verse. Tell him—

"How lovely is her iris, sir,  
Her cornea how bright;  
Her eyelids fringed with lashes long,  
React to me (and light),  
Her nasal bones sweep down with such a graceful  
curve to see,  
Her ears are delicately pink like fat with Sudan III."

and he will put the specimen back more reverently on the Museum shelf, and we shall have done something to brighten surgery.

"The Vicar of Bray" provides a good model for a short note:

"Commissionaire of forty-four,  
Complains he's short of breath sir,  
He cannot do like me and you  
Because he's fagged to death sir.  
I rather fix his appendix:  
It has a tender feel, sir,  
And so, in short, I think he ought  
To have a barium meal sir."

But let us now go down to the Theatre. Here endless changes in dress and colour are possible. I will not dwell on those. The anaesthetist should be able to play passably on the saxophone and so entertain the waiting patient. And then, what could be more appropriate than the brewer's drayman with glycosuria and a carbuncle on the back of his neck breathing into the bag whilst the anaesthetist chants:

"Sweet and low,  
Puff and blow,  
Gallons of G.O.E."

into his cyanosed and cauliflower ear? Or should he prefer more recent composers, let him have—

"Go to sleep na baby,  
Close your pretty eyes."

The singer can easily acquire the requisite nasal tone by wearing a pair of sponge forceps on his nose during this song. I believe the resulting marks are only transitory.

The surgeon addresses his staff in Blake's stirring metric—

"Bring me my swabs of snowy gauze!  
Connect the diathermy wire!  
Give me a mask!—oh! sister dear,  
Bring me my cautery of fire!  
"I will not leave this grisly scene,  
Nor shall my scalpel idle stand,  
Until I have this patient's spleen,  
Reclining in my sterile hand."

Towards the end of the operation he is annoyed that a dresser has spent the time chatting inconsequently at the back of the Theatre. He therefore addresses a rebuke, not the abrupt sort which has so often seared our membranæ tympanorum, but in Kipling's genial manner:

"Now how to do splenectomy my friend you'll never know  
By saying, 'Oh how snappy, sir,' and chatting to the pro;  
While better men than you scrub up, and spend an hour or  
more  
In picking Spencer Welles off the non-aseptic floor."

Brighter surgery is not an improvement to be considered at leisure, but a necessity which must be forthcoming.

Now a word about text-books. These are deplorably dull. I imagine that if every author was forced to write his book in rhyme, redundant descriptions would vanish, long-winded theorizing would be discouraged, and we should have no eighteen-hundred-page tome, but a portable book of verse such as would make the labyrinthine journey of the Underground a trip through the underworld of fairyland. Instead of a forbidding plain cover inscribed SURGERY, by R. E. TRACTOR, or SIMPLE CYSTOSCOPY FOR NURSES, by SISTER SCOPE, let us have on the front an attractive smiling damsel (such as often appears on popular magazines) complete in bathing costume, reclining on the beach, but with the symmetry of her lumbar vertebrae interrupted by a prominent spina bifida, and her smile marred by a hare-lip. The student, marking these defects, is all on fire to dip inside and learn how to remedy them, and the author has at once recruited a life-long devotee, sworn to overcome two of the greatest stumbling-blocks of contemporary surgery.

The academic burden of to-day is full sore and heavy. As I cast a jaded midnight eye on my shelf, bending under its load of heavy volumes, I wonder if Surgery ever will be bright! Centuries ago the complaint was

the same. Text-books and midnight oil both drained the paternal exchequer, and forced the writer of Ecclesiastes thus to warn his would-be medico:

"And further, by these, my son, be admonished: of making many books there is no end; and much study is a weariness of the flesh."

F. W. J. W.

## ANNOTATION.

### A CASE OF ASCARIS INFECTION.

A boy, *æt.* 10, was brought to the Out-Patient Department, Free-town, with severe laryngeal obstruction of a few hours' duration; restless, cyanosed, with loud stridor, recession of ribs, pulse 140. A view of the fauces could not be obtained owing to spasm of the muscles. While being examined he had a fit—head retracted, arms flexed, fists clenched, legs extended and opisthotonos. Diphtheria being almost unknown here, and the eyelids being slightly oedematous, he was given adrenalin 1/100 and atropin gr. 1/100 hypodermically. Within ten minutes stridor had ceased, and respiration was quiet and normal. Four hours later all symptoms recurred, and yielded to adrenalin alone. Next day there was slight stridor, with spasms similar to the first at intervals of a few hours, lasting a few minutes; temperature 99°-100° 5'.

The dressers all declared the condition to be tetanus, of which they see a good deal. On the third day opisthotonos was persistent and spasms frequent. Ascaris eggs being found in the faeces, santonin gr. v was administered on the fourth day. On the sixth day three large worms were expelled and all symptoms disappeared.

The writer remembers a case sent to hospital as "acute abdomen" and admitted as "encephalitis lethargica" which was relieved by the passage of a large mass of worms, and suggests that in all obscure nervous conditions, acute and chronic, in children, the faeces should be searched for eggs—before lumbar puncture if possible.

## ABERNETHIAN SOCIETY.

A clinical evening was held in the Abernethian Room on Thursday, November 10th, at 5.30 p.m. Mr. Woodrow (Vice-president) was in the Chair.

Four cases were shown: An obscure case of anaemia, by Mr. Miles. A case of multiple aneurysms, by Mr. Davy. A case of chronic osteomyelitis, by Mr. Burrows. A case of diabetic arterio-sclerosis, by Mr. Spooner.

A short discussion followed the exhibition of each one.

## CORRESPONDENCE.

### READERS' OPINIONS.

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

DEAR SIR.—I entirely agree with your correspondent "W. K. P." and "A Subscriber" in their censure of irreligious and cynical levity in a journal such as yours. In view of "M.'s" rejoinders, I should like to emphasize that there are many of your readers who are still old-fashioned enough to believe in such facts as God and the Devil, Heaven and Hell, Life and Death, Time and Eternity, in a biblical sense. We have been in Their Presence and felt Their Power. Such belief demands a sincerity and dignity in those whose profession deals with the realities of human existence.

This is not at all inimicable to a full happy life with laughter and fun, but it cuts right across the face of "garbage" such as that which calls forth this letter.

Let him who would scorn these facts first make sure that he can lay another foundation to maintain the stability of the universe. The JOURNAL has had a great past, that it may have a great future is the sincere wish of

Assani, November 7th, 1927.

Yours faithfully,  
J. NEIL LEITCH.

### OLD STUDENTS' DINNER.

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

SIR,—May I be allowed to make a few criticisms of the Old Bart.'s Dinner with a view to making the next one more popular and better attended.

First I think that the Great Hall is unsuitable. It is dark and depressing, which qualities might be relieved if the diners would sit over their wine. This apparently is not allowed, the speed of the meal being incident, the whole thing, speech included, being finished in 75 minutes. This may do for a school feast, but for a dinner of more or less mature gentlemen it is unthinkable. The majority of the Staff were conspicuous by their absence, doubtless engaged in some emergency work.

I suggest that the precincts of the Hospital do not lend themselves to gaiety amongst the old Bart.'s students, and seek of daily toil to visiting men. I think that a brighter and lighter venue might be found elsewhere in the Metropolis, where one could enjoy one's dinner with perhaps musical entertainment; and not have to move from the table till closing time if necessary.

That is my idea, for what it is worth, of making the Old Bart.'s Dinner more of a success.

Yours faithfully,  
R. MURRAY SANOW.

Roman Bank,  
Long Sutton,  
Wisbech;  
November 11th, 1927.

### NOTES ON NURSING STAFF.

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

DEAR SIR,—In certain quarters a storm of indignation has arisen concerning an article I wrote in the last number of the JOURNAL, and in which I made some remarks about the Nursing Staff.

Two particular statements I made have caused offence. Firstly I said that several things in nursing required alteration, especially the nursing of fractures of the spine and femur.

This appears to have upset certain persons (now retired), who consider that Bart.'s nursing is beyond reproach and that it cannot be perfected any further.

I am in complete agreement with the universal opinion that a Bart.'s nurse is the best trained nurse obtainable, but such an attitude as the above is likely to lead us from the paths of progress into the slough of mental stagnation and retrogression.

Medicine owes its progress to the critical faculties of its practitioners.

Secondly, I said that House Surgeons have enjoyed a better general education than the Nursing Staff. For saying this I hear that my status as a "gentleman" has been seriously called into question, but that is beside the point.

It would have been better had I been more explicit and said general medical education. Whilst realizing that nurses do all they can to acquaint themselves with some of the allied sciences of medicine, it is quite impossible for them to have anything but a nodding acquaintance with chemistry, physics, biology, anatomy, physiology and the vast sphere of pathology. They do not spend two or three years of intensive study in the dissecting-room and physiological laboratory, neither do they examine morbid specimens thoroughly, and so, through lack of time and opportunity, they cannot help having only a very superficial knowledge of these subjects.

I believe this to be true, and my motive for making this statement was not a reproachful one.

I am submitting for publication a brief survey of a few points concerning the nursing in this Hospital that in my opinion could be benefited by modification.

In hospital practice we are apt to lose sight of the ethical side of our calling. Its essentials are loyalty to one's co-workers; honesty about one's mistakes; and to treat everyone, whether he is the chief, the house surgeon or a drunken tramp, with the courtesy and kindness expected of the Medical Profession.

Yours faithfully,  
H. B. STALLARD.

St. Bartholomew's Hospital, E.C. 1;  
November 23rd, 1927.

[We regret that Mr. Stallard's article has been inevitably held over to the next issue.—Ed.]

## STUDENTS' UNION.

### RUGBY FOOTBALL CLUB.

#### ST. BARTHOLOMEW'S HOSPITAL v. CAMBRIDGE UNIVERSITY.

October 10th. For this game at Winchmore Hill, Cambridge brought down a strong side, though not their strongest. It may be said at once that while Cambridge were undoubtedly disappointing, we played better than before this season. Cambridge won by a goal from a try, a dropped goal, and 2 tries—15 points to nil. We were out-weighted forward, but we more than held our own. Outside the scrum we were beaten for pace.

From the kick-off we were pleasantly surprised to see that the forwards were holding their heavier opponents. The backs tackled well. In attack our lack of speed was unfortunately demonstrated ten minutes from the start. A passing movement was started in their "25," the ball coming across to Prowse on the left. When he received the ball Prowse was about fifteen yards from their line with no one in front of him, but he had only covered about two-thirds of that distance when he was well brought down. The backs attacked again, and Briggs was nearly over. The ball went dead. Cambridge replied by starting an attack in their "25"; they had a good overlap, but their wing was well tackled by Grace, who had come over from the opposite wing. The ball went across to the other side and one of their forwards scored far out. The good shoot at goal fell short.

Guinness made much ground by a well-judged short punt, but a forward kicked too hard and they were able to touch down. We were still tackling well but suddenly went to pieces and allowed their left wing to run along the touch-line and right round to score between the posts. The easy kick was successful. Their attacks were now looking more dangerous. During these last few minutes we were trying, but good tackling, particularly by Frederick, and valuable long kicks by Guinness and Grace kept them out. Windsor Lewis, though, dropped a beautiful goal for them from about 35 yards out in mid-field.

We were afraid that in the second half Cambridge would do much as they liked, but this was far from the case. They were playing a forward short after half time, which, of course, made some difference in the scrums. At the commencement an attack by them was kept out. We replied, but again a forward kicked too hard, and they touched down. Guinness saved a dangerous situation by remarkably good fall on the ball. Prowse was prominent with a good tackle. The only score in this half came when one of their centres was allowed to cut through. The try was not converted. Soon after this our line was again several times in danger. Frederick relieved once, getting in his kick well, and Guinness tackled their wing near the corner flag. Apart from this patch towards the end of this half, when the forwards were not getting back, we had most of the game, but we couldn't score.

At full-back Frederick tackled well, but his kicking was not good. All the three-quarters tackled well. Their three mistakes in this respect were treated perhaps too severely, two of them resulting in tries. We liked Beilby, particularly the way in which he hung on to the opponent who tried to cut in. T. P. Williams was rescued from retirement again, and he and Guinness were always useful.

We have said that the forwards scrummaged well, and maybe it is too much to expect them to be on the ball the whole time when they are out-weighted in the scrums. Still, the fact is that several times three or four forwards were struggling along many yards from the scene of action. R. N. Williams certainly has them better together now, but there is still room for improvement. We thought that Robertson, Capper and Scovell played particularly well.

Team: E. V. Frederick (back); A. H. Grace, G. F. Petty, F. J. Beilby, C. B. Prowse (three-quarters); H. W. Guinness, T. P. Williams (halves); R. N. Williams (capt.), C. K. Jenkins, G. D. S. Briggs, W. M. Capper, H. G. Edwards, H. D. Robertson, F. G. V. Scovell, V. C. Thompson (forwards).

#### ST. BARTHOLOMEW'S HOSPITAL v. OLD LEYSIANS.

This match was played on October 29th, under ideal conditions, on the Old Leysians' ground at Wandsworth Common. Gaisford was unable to play at the last moment, his place being taken by Stokes, who luckily turned up to watch. Guinness did not play, Beilby moving to fly-half and Kirkwood accompanying Petty in the centre. The Old Leysians had several reserves playing because they have been so unfortunate with injuries this season. Their run of bad luck was unfortunately continued when Carnegie Brown had

to leave the field ten minutes before the end of the first half with an injured ankle. At that time they were leading by a goal to a try, but we improved in the second half and won by three goals from tries and two goals—21 points to a goal from a try—5 points.

From the commencement our forwards showed a superiority both in the scrums and in the loose, but the passing by the backs lacked accuracy. I. P. Williams played one of his best games and was always puzzling the defence. Ten minutes from the kick-off T. P. Williams received the ball from the scrum, ran left towards the open side of the field and then turned round and flung a long pass back to Beilby on the blind side. Beilby passed to Grace, who ran well to score. Capper hit the near upright of the goal with his kick. Soon after this success a noticeable change came over the forwards, who became downright lazy, strolling about the field between the scrums in a most disgraceful manner. Ten minutes later, after more good work by T. P. Williams and Kirkwood, Petty was set going with Prowse in support on his left. He only had to pass to Prowse to give him an easy run in. Instead he elected to cut in, leaving Prowse and the open line, for their defenders coming across. The result was that an opportunity, such as is rarely presented, was lost. A few minutes later Carnegie Brown got going within our "25," but was brought down from behind by Stokes. A scrum was formed near our line and they scored a try which was converted. It was then found that Carnegie Brown had to leave the field.

In the second half the forwards threw off some of their laziness, but the Old Leysians worked like glaves, and tackled extremely well. From a line-out well in their "25" Capper secured the ball, ran on and threw the ball out to Prowse, who scored near the corner flag. Capper failed with the kick. T. P. Williams set his backs going again and again, and with Beilby understanding him better, our attacks were more dangerous. Their backs were well up on us though, and their keen tackling stopped many at the start. Soon the ball came to Prowse, who being hemmed in kicked to the centre. Jenkin was there waiting for it, but took his eye off the ball for a fraction of a second and dropped it. Stokes had a good drop at goal from about forty yards out, but fell short. The second half was nearly twenty-five minutes old when from a scrum in their "25" Beilby cut through to score on his own. Capper converted. The Old Leysians paid a brief visit to our "25," and very nearly scored. Prowse relieved well. In the last three minutes we added two more goals. First Petty interrupted and gave Grace a chance to run away from the defence to score between the posts. Secondly T. P. Williams flung a long pass directly out to Prowse, who took it extremely well and ran in behind the goal. Capper converted both.

Stokes, at back, was not overworked, but did what came his way efficiently. Both Prowse and Grace had a good day. Prowse playing particularly well. Of the centres Petty was more in the picture, but Kirkwood knows more about the game, we think, and will do better when he goes forward. Beilby played well at stand-off half and played unselfishly. T. P. Williams was in his very best form and was the genius of every attack. He always showed that he was thinking, watching them and watching his own outsiders. The forwards started well and finished well, but there was no excuse for their slack in the first half. We thought that R. N. Williams, Capper, Robertson and Scovell played well.

Team.—K. R. Stokes (back); A. H. Grace, G. F. Petty, E. M. Kirkwood, C. B. Prowse (three-quarters); F. J. Beilby, T. P. Williams (halves); R. N. Williams (capt.), C. K. Jenkins, G. D. S. Briggs, W. M. Capper, H. G. Edwards, H. D. Robertson, F. G. V. Scovell, V. C. Thompson (forwards).

#### ST. BARTHOLOMEW'S HOSPITAL v. LONDON WELSH.

November 12th. We are accustomed now to associate rain with our home matches, and this day was no exception. After a perfect morning, enough rain fell shortly before the game to spoil the handling at least in the first half. It was bitterly cold. In the first half there was no score. Early in the second half the London Welsh scored a neat dropped goal. This was followed five minutes later by Guinness scoring a try after Briggs had been well tackled near the line after a run of about 60 yards. The kick was not difficult, but was missed. It seemed to us a mistake to entrust to Dettington who was playing his first game of the season and therefore out of practice. Later each side missed fairly easy goals from penalty kicks, and on time Powell scored a good try for them which was not converted. We were beaten therefore by a dropped goal and a try 7 points to a try—3 points.

In the first half we had decidedly more of the game than our opponents and should have scored. In the second half they did better moving Powell, the international, from the centre to scrum half—his natural place. Frederick played his usual sound game at full



## UNITED HOSPITALS SAILING CLUB.

The past season has been, from many aspects, the most successful that the Club has yet had, although Bart's were unfortunate in having some rotten luck during the racing for the Sherren Cup. By a great effort the Club's boatman managed to have all four dinghies available just after Easter, and they were all in constant commission until October 31st.

In the single-handed sailing for the Wilson Cup, five of the entrants from Bart's competed in the preliminary heats on June 25th and 26th and July 16th and 17th. Bart had bad luck in toning a mark in the first round, but both Davy and Watts managed to get through to the final, in which the latter was ultimately successful.

The Kegatta was held on August 7th and 8th. The Sherren Cup (Inter-Hospital) was raced for under a new scheme. A series of races was held in which each Hospital competed an even number of times, and points were given for the place obtained in each race. The competing hospitals were: Bart's St. George's, Guy's, London, Middlesex and St. Thomas's. Each hospital was represented by a team of four, who raced in pairs. A. F. Davy, P. J. Hobday, W. A. Richards and C. F. Watts comprised the Bart's team.

Owing to a defect arising in one of the masts just before the racing, ten races of three boats had to be sailed instead of six races of four. Six races had been sailed on Saturday in a light breeze, but on Sunday the wind freshened, and in the eighth race one of the masts smashed completely. In the next race the defective mast of the spare boat was used and held. There was now one race to go, in which Bart's and London and Middlesex were competing. The points were: Guy's (5 races) 19, London (4 races) 14, Bart's (4 races) 18. Bart's had, therefore, only to get second place (3 points) to win outright—but unfortunately they drew the boat with the defective mast. They held second place, however, until the second lap when the mast went overboard and there had to be a re-sail between Bart's and Middlesex for second place. Bart's unfortunately lost this and so tied with London and Guy's with 19 points each.

This tie was re-sailed on October 15th and 16th, Bart's being represented by Hobday and Watts. There were only very light airs, and the first race was only just completed before a flat calm on Saturday evening. Each hospital won one of the three races, but Guy's secured two second places, and so won by two points.

The Annual Dinner and General Meeting of the Club are being held on Wednesday, December 7th, at the Chantier Restaurant at 7 p.m. It is hoped that as many as members possible will be present, as the future policy of the Club is to be discussed, having regard to the increasing membership and the suggested purchase of another dinghy.

If anyone who is interested in sailing would like to have further particulars of the Club, and details as to the use of dinghies by members, etc., he should communicate with me (or with the Hospital secretary). C. F. W.

## REVIEWS.

THE CONDUCT OF MEDICAL PRACTICE. By the Editor of *The Lancet* and Expert Collaborators. Price 10s. 6d.

Collections of articles reprinted from a journal or newspaper always suffer from some handicap, however well written they may be, and this book is no exception to that rule. Taken individually the matter of each chapter is admirable and evidently written by an expert and an authority on the subject, but taken as a whole the book suffers from certain defects which must inevitably narrow its appeal. The ground covered is wide and includes much material that should be included in the instruction given to the student in the medical schools—and which certainly is included in the course of forensic medicine in at least one medical school, while a substantial portion is of interest mainly to the young practitioner.

All medical students would derive profit from and find much to interest them in these pages, and in particular the chapters relating to medical secrecy, the General Medical Council, certificates and notifications, covering, advertising, sale of poisons, medical evidence, coroners, actions for damages, poisoning, contain reliable and useful information and many valuable hints, but, although the chapters are grouped together in "parts" under a common heading, the book lacks coherence. For example, no less than four chapters separate the chapter on the sale of poisons from the one which deals with poisoning and suspected poisoning—the former being grouped

with subjects associated with the General Medical Council, while the latter is a "medico-legal situation."

In the present state of the medical curriculum a large proportion of those who are granted medical diplomas find themselves legally qualified to practice but without any knowledge of their relationships to the public, the State, the law and their professional brethren. Common events which occur often in nearly all practices find them utterly unprepared and the result may be a serious loss of prestige, if nothing worse. In some medical schools this subject is dealt with as far as the allotted time permits, but the relative importance of this instruction is not at present recognized. The whole book therefore can be regarded as a useful supplement to the existing inadequate preparation for practice.

Its slight tendency to prosiness may deter the average undergraduate from any serious study of this volume, but every medical practitioner will find most of it interesting and helpful. For the newly qualified practitioner it should be regarded as an essential introduction to medical practice, the sections dealing with *panel practice*, medical assistants and partnerships, the public services, and income tax being particularly valuable.

IN PURSUIT OF TRUTH: A COMPARATIVE STUDY IN SCIENCE AND RELIGION. BY ALEX. WOOD, M.A., D.Sc. (London: Student Christian Movement, 1927.) Pp. 122. Price 4s. net.

The greater part of this book is devoted to an elementary criticism of the methods and limitations of scientific thought. The argument, developed to show the conceptual (as opposed to the real) nature of scientific thought, is reasonable, though the occurrence of loose statements such as "The method of interpreting the complex in terms of the simple is logically tantamount to a reduction of the more to the less (italics added), and therefore a denial of the fact to be explained," imposes the necessity of careful scrutiny of Dr. Wood's simplest arguments.

In his concluding chapter, Dr. Woods begins his comparative study in earnest. Scientific reasoning is applied to religious reasoning:

Religion, like science, is a response to man's need of something to correlate his experiences, and to the impulse to "relate, to systematize, to make intelligible." A religious induction, like a scientific induction, must illumine both past and future experiences. Jesus Christ is the great induction. Though verifications do not make an induction infallible, verification is the intellectual test of religious truth. In verification we find that religion is progressive, and if religious truth is *improvable*, it is no proof that Jesus Christ is an incomplete revelation, but that our explanation of the revelation is incomplete. If this induction does not illumine as it should, it is as well for the student mind to leave such artificial puzzles that have no practical bearing. Perhaps, too, it would be dull if there was nothing more to be illumined and all was clear. Again, too much must not be demanded of so all-embracing an induction. It is worth while hanging on to inconsistencies which may be reconciled than to go for a premature logical consistency. The life and personality of Christ is the great induction. We must verify it in our own lives. Such verification can only be of value through a direct experience of God.

The argument is sketched here at length to show its inconsistencies. We are first exhorted to use an induction we do not fully understand, and some inadequate illogical reasons are given for its possibly restricted use. We are to approach the verification (which the author states can never make an induction infallibly true!) of an induction by experience of that great induction—the experience of God.

The chapter is a glib rationalization of a system based on purely subjective religious intuitions (about which there can be no final agreement) by methods applicable only to systems based on objective facts about which there is a reasonable consensus of opinion. The result is nonsense, and can only strengthen the sceptic, bewilder the believer, or, what is probably more pernicious, foster predilections for loose and woolly thinking.

HYMNS, OR THE FUTURE OF MARRIAGE. BY NORMAN HAIRE. (London: Kegan Paul, Trench, Trübner & Co., Ltd., 1927.) Price 2s. 6d.

*Life-long monogamous marriage is, I believe, the ideal to aim at.* So Dr. Haire italicizes his orthodoxy, disarming the prejudices of those who regard an essay titled by a Mediterranean name as one to be read with circumspection. But, like Andrew Undershaft,

Dr. Haire may be accused of finding immoral reasons for eying the moral thing. He substitutes biological objections for prejudice, based (he finds) on Jewish morality, to incest and other sex perversions. The monograph surveys briefly the whole field of sexology (Sexology! One loves for a Fowler to deliver us from so dissipated a hybrid). Sex education, pre-marital relations, and prostitution are treated much as Mr. Shaw and Mr. Wells have treated them. The future is to be in the hands of the psychologist rather than in the law-maker's, while birth-control, sterilization and eugenetics may be commonplace of the new age.

Dr. Haire is sound, interesting, and keeps to the point. He is also depressing, perhaps because he has no place for that marital glamour which, to some minds, is the only gift to the pill. But the depression is salutary.

MATERIA MEDICA, PHARMACY, PHARMACOLOGY AND THERAPEUTICS. BY SIR WILLIAM HALE WHITE, K.B.E., M.D. (Lond.), M.D. (Dub.), LL.D. (Edin.), 19th edition. (London: J. & A. Churchill, 1927.) Pp. 712.

This most convenient little book is known to so many students and practitioners in its earlier editions that the present one needs little description.

The older sections on therapeutics and pharmacology have been revised and brought completely up to date, and to them have been added descriptions of some newer drugs and treatments.

Among these are sacrosanin, parathyroid, various antisera, protein therapy, bismuth in syphilis and lead in cancer.

The great advantage of this book is that it contains all that the average man wants to know about the standard drugs and their administration in a compact, pleasant and very useful form.

MIND AND ITS MECHANISM. BY PAUL ROUSFIELD, M.R.C.S., I.R.C.P., and W. R. ROUSFIELD, K.C., F.R.S.

It is some time since one has read a book of such interest, presenting, as it does, quite a novel conception of the nature and working of the human mind. It would appear that the main theory brought forward is of a mechanistic character, being based on the assumption that "psychons" and "psycho-plasm" are the fundamentals of mind. This hypothesis undoubtedly places the views thus held on a similar basis to those held by physicists as to the part played by protons and electrons in the material world, but only differing in order of magnitude.

This theory of a central psychic organ with its material and dynamic elements, although very attractive, must certainly trespass against the views held by many psychologists.

The authors do not show any acquaintance of the "wave mechanics" of Schrödinger and others, yet in their hypothesis they are obviously endeavouring to keep abreast of modern developments in intra-atomic mechanics—an attempt which must assuredly commend itself to followers of physiognomy.

From this aspect the authors propound the "principle of resonance," which, by a system of "resonators" of varying vibratory indices and reactions, provides a materialistic framework upon which the working of mind is carried out. Their theory of etheric wave action in the domain of human psychology is greatly enhanced by attractive and stimulating subject matter, which provides valuable material for future speculation by students of psychology and others who desire to approach the subject from a more materialistic point of view.

The book is full of quotations, some of considerable length, but none the less extremely instructive, and the method of summarizing at the end of each chapter greatly amplifies the value of the book.

In dealing with the Lamarckian theory of evolution at some great length, the authors have provided illuminating material and convincing proofs of this hitherto rejected doctrine. The book is cleverly written in an agreeable style, and the authors are to be congratulated in propounding a conception of so novel and fascinating a character with regard to the mind and its mechanism, and it may indeed prove the foundation stone of a new school of psychological thought.

CLINICAL RESEARCHES IN ACUTE ABDOMINAL DISEASE. BY ZACHARY COPE. Second edition. (Oxford University Press: Humphrey Milford.) Pp. 214. Price 10s. 6d. net.

The second edition of this well-known book includes a new chapter on "Extravasation of Bile," based on a Hunterian lecture in 1925, a short note on a rare form of ascending enteritis causing intestinal

obstruction, published, like the other, in the *British Journal of Surgery*, and a hitherto unpublished research on the subject of shock. This long and interesting chapter arrives at a definition of "shock" in its less aggravated form, the compensating mechanism by which, for instance, the abdomen may be full of blood and yet the pulse may remain normal in frequency and of good volume, being treated. A very full account is given of shock in abdominal disease, with illustrative cases. An instructive analogy is drawn between secondary wound shock and shock following relief of obstruction due to a band. There are a number of new illustrations, chiefly in connection with this chapter. A good book for the more advanced, but always interesting reading.

MODERN METHODS IN THE DIAGNOSIS AND TREATMENT OF GLYCOCURIA AND DIABETES. BY HUGH MACLEAN. Pp. 212. Price 12s.

This book is addressed to the busy practitioner and should prove a safe guide to those unfamiliar with the modern treatment of diabetes. It contains a valuable description of the varieties of blood-sugar curves commonly found and of their relation to glycosuria of no serious import. The detailed accounts of the simple routine tests are welcome, but it appears doubtful if the space devoted to the more complicated determinations, such as that of the plasma bicarbonate, is as well utilized.

Prof. Maclean still advocates treatment by fasting for periods as long as five days, and his ladder diet contains weekly fast days. The value of this policy has been challenged in many quarters, and it is of interest to find Prof. Maclean advocating it so strongly. He seems rather unduly reluctant to advocate insulin therapy for cases not readily controlled by diet.

In the treatment of coma he rightly emphasizes the importance of combating the circulatory collapse, but he ignores the fact that infections play an important part in precipitating acidosis and coma, and the need for a thorough search for such complications.

THE CANCER QUESTION. TOMLINSON. (London: Baillière, Tindall & Cox, 1927.) Price 2s. 6d.

This handbook, on a new theory of the causation of malignant disease, is in the main a recapitulation of the various known theories, with a further suggestion by the author, which is unsupported by any scientific evidence. We cannot recommend its study.

## RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

GREEN, F. H. K., M.B., B.S., M.R.C.P. See Linder, Maxwell and Green, GIFFITHS, H. ERNEST, M.S., F.R.C.S. "Chronic Pancreatitis." *Lancet*, July 23rd, 1927.

HADFIELD, GEOFFREY, M.D. (A. J. WRIGHT and G. H.). "Carcinoma of the Esophagus: Treatment by Diathermy." *British Journal of Surgery*, July, 1927.

HALL, PERCY, M.R.C.S., L.R.C.P. "Actino-therapy in Skin Disease." *British Journal of Actino-Therapy*, October, 1926.

HEWER, C. LANGTON, M.B., B.S., M.R.C.S., L.R.C.P. "The Therapeutic Value of Carbon Dioxide." *Clinical Journal*, July 20th, 1927.

HEY GROVES, ERNEST W., M.D., F.R.C.S. "Some Remarks on our Present Hospital System." *British Medical Journal*, July 23rd, 1927.

HURRY, JAMIESON B., M.A., M.D. *Poverty and its Vicious Circles*. Chinese edition, 1927.

LINDER, GEOFFREY C., M.D., M.R.C.P. (and MAXWELL, J., M.D., M.R.C.P., and GREEN, F. H. K., M.B., B.S., M.R.C.P.). "A Clinical, Pathological and Biochemical Study of Amyloid Nephrosis." *Archives Disease in Childhood*, August, 1927.

LOW, G. CARMICHAEL, M.A., M.D., F.R.C.P. (and D. BENTON, M.R.C.S., L.R.C.P.). "Sprue in Natives." *Journal of Tropical Medicine and Hygiene*, August 1st, 1927.

MANSSELL, R. A., M.B.E., R.A.M.C. (Major F. M. LISCOMB and R. A. M.). "A Case of Congenital Malacia." *Journal Royal Army Medical Corps*, July, 1927.

MAXWELL, J., M.D., M.R.C.P. See Linder, Maxwell and Green. MITCHELL, W. E. M., M.C., M.B., B.S., F.R.C.S. "The Preparation of Patients for Operation." *Lancet*, August 6th, 1927.



- NICOL, W. D., M.R.C.S., L.R.C.P., D.P.M. "The Care and Management of Induced Malaria." *Journal of Mental Science*, April, 1927.
- POWER, Sir D'ARCY, K.B.E., F.R.C.S. "A System of Surgery," by Master John Arderne. *British Journal of Surgery*, July, 1927.
- ROCHE, ALEX. E., M.A., M.D., M.Ch.(Camb.), F.R.C.S. "The Value of Pyelography in Renal Diagnosis." *Clinical Journal*, July 27th, 1927.
- ROLLESTON, Sir HUMPHRY, Bart., K.C.B., M.D., F.R.C.P. "Clinical Variations in Disease from the Historical Point of View." *British Medical Journal*, August 6th, 1927.
- SHORE, L. R., M.A., M.B., M.R.C.P., D.P.H. "On Strains in the Muscles concerned in Respiration." *Clinical Journal*, August 24th, 1927.
- STONE, G. KENNETH, D.M., M.R.C.P. "Fundamental Principles in the Vaccine Treatment of Chronic Arthritis." *Practitioner*, September, 1927.
- WALKER, KENNETH M., M.A., M.B., B.C., F.R.C.S. "An Address on the Treatment of Genital Tuberculosis in the Male." *Lancet*, August 26th, 1927.
- WHITTINGDALE, JOHN, M.A., M.B., F.R.C.S. "Pain in the Right Iliac Fossa." *Clinical Journal*, August 17th, 1927.
- WILLOUGHBY, W. M., M.D., B.Ch., D.P.H. "Tuberculosis: A Note on the Health of Crews and Ship Hygiene." *Medical Officer*, August 13th, 1927.

### EXAMINATIONS, ETC.

#### UNIVERSITY OF CAMBRIDGE.

The following degree has been conferred:  
*B.Chir.*—Walker, F. H. A.

#### UNIVERSITY OF WALES.

*D.P.H.*—Donelan, C. J.  
ROYAL COLLEGE OF PHYSICIANS.  
The following have been admitted members:  
Dicks, H. V., Erian, A.

#### CONJOINT EXAMINING BOARD.

*Pre-Medical Examination, October, 1927.*  
*Chemistry.*—Ford, A. R., Morgan, G. O., Hole, F. K.  
*Physics.*—Ford, A. R., Morgan, G. O.

#### First Examination.

*Part I. Anatomy.*—Little, G. S. R.  
*Part I. Physiology.*—Rowe, J. T., Knox, J. S.  
*Second Examination (Old Regulations).*  
*Part I. Anatomy.*—Adams, F. P.  
*Part II. Pharmacology and Materia Medica.*—Wallace, A. F.

The following have completed the examination for the Diploma of M.R.C.S., L.R.C.P., and had the Diplomas conferred upon them:  
Beattie, W. J. H. M., Clark, W. A., Colman, N. B., Drake, E. C. C., Farfel, S., Hutton, W. A., James, E. T., Knowles, K., Mr-Master, A. M., Nicholson, W. A., Pagan, A. T., Pimblett, G. W., Preiskel, D., Rainey, P. R., Roache, W. V., Robertson, I. M., Roderick, R., Russian, A. de la C., Salt, P. G., Sinclair, M. R., Spooner, F. T. C., Tweedie, D. R., Wilkin, W. J., Wood, W. A.

### CHANGES OF ADDRESS.

BELL, Surgeon Commander K. DIBBY, R.N., No. 1 Residence, The Royal Marine Depot, Eastney, Portsmouth.  
BROWN, R., 185, Evering Road, Upper Clapton, E. 5.  
CHOLMELEY, M. A., Strutton House, Church Street, Salop.  
CURRY, F. F. N., 50, Strada It torri, Sliema, Malta.  
DE CAUX, F. P., 75, Weymouth Street, W. 1.  
DICKS, H. V., 45, Leicester Square, Baywater, W. 2.  
FARFEL, S., 42, Regents Street, Yeoville, Johannesburg, S. Africa.  
GARROD, Sir ARCHIBALD F., Wilford Lodge, Melton, nr. Woodbridge, Suffolk.  
MALTRY, H. W., 56, Rectory Road, Stoke Newington, N. 16.  
MOIR, E. D., 24, Guilford Street, W. C. 1. (Tel. Museum 6261.)  
OWEN, E. F. D., The Clinic, The Sherwood Colliery Company, Mansfield, Notts.  
SODEN, W. N., Leopardstown Park Hospital, Stillorgan, co. Dublin.

STORRS, Lt.-Col. R., R.A.M.C., Officers Mess, Freetown, Sierra Leone.  
WIGAN, W. C., Mpondas, Fort Johnston, Nyassaland.

### APPOINTMENTS.

BESTON, D., M.R.C.S., L.R.C.P., appointed House Surgeon to the Queen's Hospital for Children, Hackney.  
DARLEY, W. W., M.R.C.S., L.R.C.P., appointed House Surgeon to the Dudley Road Hospital, Birmingham.  
DAVIES, C. SIMS, M.R.C.S., L.R.C.P., appointed Senior Resident Medical Officer to the General Infirmary, Worcester.  
OWEN, E. F. D., M.R.C.S., L.R.C.P., appointed Chief Medical Officer to the Mansfield Clinic, Notts.  
SPARKS, J. V., M.R.C.S., D.M.R.E.(Cams.), appointed Hon. Radio Logist to the Alexandra Hospital, Swanley.  
WEST, R. G. RANBYARD, M.B., M.R.C.P., D.P.H., appointed Assistant Tuberculosis Officer to the County of Warwickshire.

### BIRTHS.

DE CAUX.—On October 29th, 1927, at 25, Weymouth Street, to Jeanette, wife of Dr. Francis Percival de Caux—a son.  
HECKFORD.—On September 27th, 1927, at Chichester, Sussex, to Gwendolen Louise, wife of Dr. Frank Heckford—twin sons.  
MOORE.—On November 10th, 1927, at 27, Welbeck Street, Mary, the wife of Sir Alan Moore, Bart., of a daughter.  
SCOTT BROWN.—On November 9th, 1927, at Riverhead, Sevenoaks, to Peggy (*née* Bannerman), wife of W. G. Scott Brown, M.B., B.Ch.(Camb.)—a daughter.  
VERNEY.—On October 30th, 1927, at 28, Clifton Avenue, London, N. 3, to Ruth (*née* Conway), wife of E. B. Verney—a son.  
WELLS.—On November 18th, 1927, at West Bar, Banbury, to Vera (*née* Grantham-Hill) and Dr. C. J. L. Wells—a daughter.

### MARRIAGES.

CRONK SHARP. On November 14th, 1927, at St. Stephen's, Hampstead, N.W., by the Right Rev. the Lord Bishop of Ely, Herbert George Cronk, M.B., to Mary Sharp, late of Sarawak. (Australian, Singapore and Borneo papers please copy.)  
DICKS—JEFFERY.—On November 19th, 1927, at St. Andrew's, Holborn, by the Vicar, Henry Victor Dicks, to Maud Jeffery.  
PEARSON—BURN.—On October 22nd, at Eaton Parish Church, Herbert William, youngest son of Mr. and Mrs. Pearson, Cheltenham, to Ethelene Mabel, daughter of Mr. and Mrs. Bunn, Norwich.  
SOUTHAM—FOOT.—On November 21st, 1927, at all Saints', Ennis more Gardens, by the Rev. Eric Southam, assisted by the Rev. A. H. Streeten, Arthur H. Southam, younger son of the late Mr. and Mrs. F. A. Southam, of Manchester, to Dora L. Foot, elder daughter of the late Mr. W. H. Foot, of Putney, and Mrs. H. Foot, of Esher.

### DEATHS.

CHOLMELEY.—On October 30th, 1927, at Forest Edge, Forest Road, Sussex, Henry Patrick Cholmeley, M.D.(Oxon.), aged 68.  
LANGFORD.—On November 1st, 1927, at "Chocoma," *Cantiford*, suddenly of heart failure, Charles Harris Langford, M.R.(Lond.)  
SLOMAN.—On November 5th, 1927, at 5, The Mount, St. Leonards-on-Sea, Herbert Sloman, M.R.C.S., L.R.C.P., aged 74.  
THOMPSON.—On November 12th, 1927, at Stargill, Kew Road, Richmond, suddenly, Maitland Thompson, M.R.C.S.(Eng.), L.R.C.P., L.M.(Edin.), formerly of Hemel Hempstead, Herts, aged 66.  
WOOD.—On October 30th, 1927, at Hockwold, Brandon, Suffolk, after a long illness, Henry Utting Wood, M.R.C.S., L.R.C.P.

### 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, E.C. 1.

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., at the Hospital.

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0310.

# St. Bartholomew's Hospital



## JOURNAL.

"Aquam memento rebus in arduis  
Servare mentem."

—Horace, Book II, Ode III.

VOL. XXXV.—No. 4.]

JANUARY 1ST, 1928.

PRICE NINEPENCE.

### CALENDAR.

Tues, Jan. 3.—Prof. Fraser and Prof. Gask on duty.  
Tues, Wed, Thurs, Fri, Jan 3, 4, 5 and 6.—Nightly at 8.0.  
**The Amateur Dramatic Society presents:**  
**"Ask Beccles."**  
Fri., Jan. 6.—Dr. Morley Fletcher and Sir Holburt Waring on duty.  
Sat. " 7.—Rugby Match v. Harlequins. Home.  
Hockey Match v. Shoburyness Garrison. Away.  
Tues., " 10.—Sir Percival Hartley and Mr. McAdam Eccles on duty.  
Fri., " 13.—Sir Thomas Horder and Mr. L. B. Rawling on duty.  
Sat., " 14.—Rugby Match v. Bradford. Home.  
Hockey Match v. Royal Navy, Chatham. Away.  
Mon., " 16.—Special Subject. Clinical Lecture by Mr. Harmer.  
Tues., " 17.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.  
Wed., " 18.—Surgery. Clinical Lecture by Sir Holburt Waring.  
Fri., " 20.—Prof. Fraser and Prof. Gask on duty.  
Medicine. Clinical Lecture.  
Sat., " 21.—Rugby Match v. Coventry. Home.  
Hockey Match v. Radlett. Home.  
**Last day for receiving matter for the February issue of the Journal.**  
Mon., " 23.—Special Subject. Clinical Lecture by Mr. Just.  
Tues., " 24.—Dr. Morley Fletcher and Sir Holburt Waring on duty.  
Wed., " 25.—Surgery. Clinical Lecture by Sir Holburt Waring.  
Fri., " 27.—Sir Percival Hartley and Mr. McAdam Eccles on duty.  
Medicine. Clinical Lecture by Sir Thomas Horder.  
Sat., " 28.—Rugby Match v. Old Blues. Away.  
Hockey Match v. St. Albans. Away.  
Mon., " 30.—Special Subject. Clinical Lecture by Mr. Cumberland.  
Tues., " 31.—Sir Thomas Horder and Mr. L. B. Rawling on duty.

### EDITORIAL.

**T**HE festive season is not without its trials, neither are its trials lacking in interest. The weather made a magnificent attempt to provide a Christmas card setting for us Londoners, only bursting a few drains and freezing our water jugs in the process. We regarded its efforts with kindly, though chill interest. The sudden thaw gave a new significance to the time-worn phrase "treacherous weather." Spoilt picnics and nasal catarrh are mere misdemeanours compared with the outrageous felony of that sudden relenting thaw. The Surgery was a perspiring crowd of policemen, vainly licking moribund pencil points to give colour to the massive evidence they had accumulated. Two hundred and ten casualties arrived between seven a.m. and one p.m. Apart from minor accidents and a few fractured humeri and femora, two dislocated shoulders, two dislocated hips, and twenty-two Colles' fractures were treated. Intrepid souls may deny this as a record, but they cannot deny the singularity of a casualty surgeon who thereby got his breakfast at two in the afternoon.

\* \* \*

Feminists will be pleased to hear that the male casualties slightly exceeded the female. This appears a suitable reply to the statements that (a) high heels make walking impossible and dangerous, and (b) women have much less adaptability to circumstances than men. The more masculine minded may take heart; anything can be proved by statistics.

\* \* \*

*Round the Fountain* is "out." For the benefit of those who have misplaced the order sheet which accompanied last month's issue, we wish to state that the

Edition de Luxe (limited to five hundred copies) costs seven and sixpence, seven and elevenpence post free. The Ordinary Edition costs three and sixpence, three and tenpence post free.

We will not dwell upon the advantages of possessing a copy of this illustrated and enlarged edition. Rather would we point out to those who have copies of their own how suitable a New Year's gift it makes.

\* \* \*

Dr. N. G. Horner has been appointed to succeed Sir Dawson Williams as Editor of the *British Medical Journal*. We offer our congratulations.

\* \* \*

Sir Archibald Garrod has retired from the Chair of Physics at Oxford in accordance with the age limit set by a Commission of which he himself was a member.

His retirement is a magnanimous proof of his sincere advocacy of a retiring age, for Sir Archibald is not subject to the new ruling. We wish him happiness at his home at Melton, and hope that he may long continue with his valuable editorial and committee work.

\* \* \*

We extend our sympathies to Professor Kettle on his continued illness, and wish him a speedy recovery.

\* \* \*

#### CHRISTMAS.

The difficulties in transit occasioned by a heavy fall of snow made the attendance of visitors at the Christmas festivities a small one this year. This was a pity, for the wards have never been more attractively decorated, and the entertainments provided were varied and of a high standard.

Having at length reached the Hospital without the aid of skis, we made it our business to see as many shows as possible. Even so we were unable to run the whole gamut of attractions; criticism, therefore, of individual shows must be invidious. Suffice it to say that for sheer technique and "pep" the Residents' "Oh Boy" struck us as being the most effective performance we had seen in the wards for years past. Messrs. Hunter and Roxburgh, both as cross-talk comedians and duettists, showed how easily experienced artists can carry off a show of this nature with a minimum of rehearsal. Actually, so we are told, "Oh Boy" was only rehearsed three times.

The "Pink" firm, under the title of "Ask (B) Eccles," lived up to the excellence of their poster. We need hardly say more.

The "Doty Barristers" had some clever "personal" verses and a particularly good *ensemble finale*. The

"Gasktronomes," assisted by an excellent conjuror, gave an enjoyable show; their performance of the "muddled broadcasting" item was professional in its finish. The "Superficial Sunnies" excelled in topical and personal allusion; theirs, too, was a cheerful and efficient performance. The "Rawling Firm" and the "Phithetacysts" were unfortunately unable to see for want of time. Jock Stilton's Band we heard for a few minutes only, and what we heard was good.

Major Cartwright and the "Light Blue" Firm did yeoman work with their cinemas; many a warded "movie-fan" seemed stimulated to new life by their efforts. On the side of more serious entertainment the Richards Quartette was a delight, and provided a welcome intermission between the many more facetious performances.

\* \* \*

The Party in the Surgery on the "official" Boxing Day was a crowded and happy affair. Community singing, child dancers, a conjuror and a Punch and Judy show contributed to the enjoyment of children and adults alike. It was good to hear the high-pitched Cockney chorus of "Wake up!" (or more accurately, "Waikie up") addressed to the artful Joey in the Punch and Judy show when Mr. Punch, heavily armed, arrived on the scene to find him sleeping. It has been said that Punch and Judy shows, like pantomime, are dying out; this afternoon's experience made us wonder why they should ever die. As usual the culminating point in the party was the arrival of Father Christmas, who apparently was twins unless we suffered from diplopia.

Messrs. Evans and Nixon, looking as like as two pins, a couple of really benevolent old gentlemen, arrived from arctic regions in time to distribute presents to every one in the party. Again the delighted shouts of the children as each received a gift were a joy to hear; especially fortunate was the little girl who received a doll, accurately attired in Sisters' uniform. "We're going to 'ave our photos took," she said. A hurried comparison of presents; a husky dialogue, "What have you got? I got a Teddy!" a huge tea, and then home to bed and possibly indigestion.

But who fears indigestion on a day like this?

\* \* \*

#### OVERHEARD IN THE SKIN DEPARTMENT.

*Patient:* The stuff that did me best was the Cinard ointment, doctor.

*Doctor:* What was it like?

*Patient:* Dark stuff, doctor.

*Doctor* (looking at card): You don't mean White's tar ointment, do you?

*Patient:* Yes. That's it. White Star.

## A CASE OF MESENTERIC EMBOLISM.

**A** RECENT classical case of mesenteric embolism, for permission to report which I am indebted to Mr. Rawling, may serve as a peg on which to hang a short review of this rare condition, together with the allied one of mesenteric thrombosis.

A. S.—, a Jewess, aged 49, arrived at hospital on Monday afternoon, October 3rd, 1927, with a doctor's note to the effect that, having had mitral stenosis for seven to eight years, she had had an "acute attack of pain in the leg, ? embolism," three weeks ago, and had been in another hospital for about two weeks, when she discharged herself. For three days she had had acute abdominal pain, distension, and tenderness, but no vomiting; the bowels had been opened with an enema on the previous day. The doctor added, with diagnostic acumen, "She is either a case of mesenteric thrombosis, or acute general peritonitis secondary to an ? appendix."

The patient looked very ill, and could hardly understand or answer questions. One gathered that she had never before had similar abdominal pain, and that it had commenced suddenly on September 30th, ? in the lower abdomen, then all over it. She said that she had not since passed flatus, but also that the bowels were opened very slightly on the previous day. She had vomited some milk on October 1st, and brought up wind. Three weeks previously, while in hospital, she had had sudden pain in the left leg (she pointed from just below the knee to the toes), which did not swell.

The pulse was 98, and irregular, temperature 100.2° F., respirations 24, tongue dryish, abdomen tender and very distended, especially in its lower half. The flanks were resonant. Two observers diagnosed mesenteric embolism.

Mr. Rawling made a median sub-umbilical incision. On opening the peritoneal cavity, blood-stained fluid escaped, and bluish undistended small bowel presented, showing multiple black areas. Its peritoneal coat was still shiny, and there was no lymph on it. The abdomen was rapidly closed, and death occurred ten minutes afterwards. There was no post-mortem examination.

Subsequent communication with the other hospital revealed some interesting additional details, which would still further have facilitated the diagnosis.

She had been admitted there on September 13th, fibrillating and dyspnoic, with very faint left femoral pulsation, and none in the left popliteal artery. The left leg, in which on the previous day she had had sudden

pain, was colder than the right. Digitalis was given, and the femoral pulsation gradually improved.

On September 29th, at 4.30 p.m., after calling for the bed-pan, she had sudden upper abdominal pain. She was not dyspnoic. The abdominal wall was slack, not tender, and moved on respiration. Morphia, gr.  $\frac{1}{4}$ , was given, and a further dose given during the night.

On September 30th she vomited several times, and passed bright blood in a liquid stool.

On October 1st she passed two liquid stools, vomited once, and discharged herself, as "she wished to die at home." She was considered to have a mesenteric embolus.

Of mesenteric vascular blockage it has been said that "the diagnosis is impossible, the prognosis hopeless, and the treatment almost useless." A perusal of Cokkinis's interesting recent monograph, in which he attempts to combat the above view, and from which the following account is abstracted, leaves one with the impression that diagnosis, indeed, may be sometimes possible, especially if the condition is borne in mind; but the facts that the operative mortality is about 80%, and that further post-operative vascular blockage may occur, are evidences of the unfortunately large degree of truth in the above aphorism.

The condition is found about equally in males and females, and at any age, but especially in young and middle-aged adults, and should be more frequently remembered than it is, as its incidence is probably somewhat greater than that of volvulus, and over three times that of chronic intussusception.

The vascular block may be arterial or venous. When it is arterial, embolism is the usual cause, and its most common source an inflamed mitral valve, arterial thrombosis being very rarely primary, but nearly always secondary to embolism. It is, however, a most important sequel, as the distal extension of thrombosis from the site of embolism interferes with the collateral circulation of the bowel. The superior mesenteric artery is very much more frequently affected than the inferior, perhaps because the former has twice the latter's calibre, and is more nearly parallel to the aorta, from which it arises higher.

Venous blockage, on the other hand, is always primarily thrombotic, venous embolism, should it occur, being secondary to the thrombotic process. The thrombosis itself is nearly always dependent on portal obstruction or peripheral sepsis, the commonest source of the latter being acute appendicitis.

Cokkinis quotes and adduces evidence to show that, owing to its feeble anastomosis with other arteries, the superior mesenteric artery, when blocked above the origin of its branches, behaves as an end-artery, with

consequent cutting-off of the blood-supply of almost the entire small intestine, together with the cæcum and ascending colon.

When, however, as is more frequently the case, the block is a low one, the superior mesenteric artery does not behave as an end-artery, owing to the rich anastomosis of its branches with one another. This would probably often suffice to maintain the blood-supply of the bowel involved, were it not for the peripheral extension of thrombosis from the site of embolism, which abolishes the collateral circulation. It is this downward and lateral spread of thrombosis, for the development of which some time is necessary, which is of vital importance in mesenteric embolism, and which makes early surgical intervention urgently imperative (more so than in almost any other acute abdominal lesion), in order that the operation may concern itself with the sufficiently serious effects of the primary block, without having, in addition, to deal with the too commonly fatal results of its secondary extensions.

Besides the peripheral spread of thrombosis, two other factors increase the field of primary damage. One is the widening area of circulatory interference caused by exudation in the mesentery, which, by pressing on neighbouring vessels, causes further exudation and pressure. The other is spreading infective gangrene of the devitalised areas. In fact, to vary a popular metaphor, a vicious triangle is produced, with the primary vascular block as its apex.

In contrast with mesenteric arterial embolism, venous thrombosis is of gradual onset, and the collateral circulation in the veins is better, as they are more distensible than the arteries, and have more time in which to accommodate themselves to altered conditions. Thus, complete obstruction of the portal or of either mesenteric vein may exist without functional effect on the bowel.

The most common effect on the bowel of mesenteric vascular blockage, whether arterial or venous, is hæmorrhagic infarction, this being found in over 50% of all cases. The main cause of infarction of the bowel is the spread of thrombosis to the anastomosing arcades, there being no anastomosis beyond the terminal row of these.

The changes are similar to those seen on a small scale in strangulated hernia, consisting at first of congestion and œdema of the bowel. In the case of mesenteric embolism there is said to be a back-flow in the valveless veins at any rate, there is an absence of the "vis a tergo," and venous engorgement results, as, of course, in the more obvious case of mesenteric venous blockage.

Later on, blood is extravasated into the bowel-wall,

constituting hæmorrhagic infarction. The bowel is now nearly black, inelastic, and non-viable, and an easy prey to the organisms in its lumen, which cause terminal infective gangrene.

Except in diffuse infarction, it is the small intestine, especially in its lower part, which is usually affected; and it is important to note that a definite line of demarcation is exceptional, there being usually a gradual transition from infarcted, through congested, to normal, bowel.

Blood is extravasated not only into the bowel-wall, but also into its lumen and into the peritoneal cavity and mesentery. The lateral spread of the infarcting process in the mesentery is an urgent reason for early and wide resection of damaged parts.

A review of the underlying pathology of mesenteric vascular blockage facilitates consideration of its variable clinical aspects.

The onset is usually sudden, with intense general abdominal colicky pain and shock, soon followed by repeated vomiting. There is then often a latent period before the resultant altered bowel action, which shows itself either as bloody diarrhœa or as paralytic ileus. Somewhat paradoxically, these may co-exist, the former (as also hæmatemesis, which occurs in 25 to 30% of cases) being the reaction of the congested and irritated areas; the latter, that of the intermediate infarcted and paretic area.

In order to bring away blood lying in paralysed bowel, Cokkinis advocates the administration of an enema to all patients in whose cases mesenteric vascular blockage enters into the differential diagnosis.

Symptoms of hæmorrhage, such as restlessness, faintness, and thirst, are not infrequent; but rigors are rare.

The patient is obviously extremely ill, pale, cold and collapsed, with a rapid and steadily rising pulse-rate, and a temperature which is usually subnormal after a slight reactionary rise following on the primary shock. The abdomen is distended and shows signs of free fluid. The distension (seen in 65% of cases) occurs early, and is frequently great. General abdominal tenderness (64%) is more noticeable than rigidity (45%).

Cokkinis distinguishes four clinical groups of this variable affection:

- (1) The latent group—a mere incident in pyæmia, portal obstruction, or appendicitis.
- (2) The acute obstructive group, simulating internal strangulation.
- (3) The characteristic acute hæmorrhagic group.
- (4) The chronic group.

These chronic cases, forming 21% of the total, are important, since a history of abdominal pain, indigestion, flatulence, or hæmatemesis of some months'

duration, may be ascribed to duodenal ulcer, appendicitis, or other affections.

The main conditions which enter into the differential diagnosis are:

- (1) Acute intestinal obstruction of special type, particularly volvulus and internal strangulation.
- (2) Acute peritonitis, as in perforation of a peptic ulcer or of an appendix.
- (3) Severe hæmorrhage in hepatic cirrhosis or peptic ulcer.
- (4) Acute pancreatitis.

In the difficult task of distinguishing mesenteric vascular blockage from these affections, of supreme importance would be—

- (1) Evidence of a causal lesion.
- (2) Evidence of vascular blockage elsewhere.
- (3) The occurrence of bloody diarrhœa.

Acute mesenteric vascular blockage, in the absence of operation, has a mortality of about 95%, death occurring, on the average, within three days from the onset of symptoms.

Immediate laparotomy is urgent, and may be achieved by a 6-in. paramedian incision,  $\frac{1}{3}$  above, and  $\frac{2}{3}$  below, the umbilicus, when blood-stained intra-peritoneal fluid and infarcted bowel provide or confirm the diagnosis. Wide resection of involved bowel and mesentery is needed, if the patient's condition allows, the bowel being cut at least a foot away from the congested area, with end-to-end union in the common case of small bowel (of which as much as 15 ft. has been successfully removed), or drainage in the rare case of large bowel.

Of 76 cases, 40 were not operated upon, and 39 died (mortality 97.5%). The other 36 underwent operation, with an 83% mortality, 6 of them recovering. Of the 12 patients in whom resection was done, 5 survived, giving a mortality of 58%. Of these 12 cases, only 1 occurred before 1918, and 11 since; and this encourages one to hope with Cokkinis that more frequent diagnosis and earlier operation will increase the number of cases in which resection is possible. One may also share his hope that the results of resection will be better when this is carried out more widely of the damaged parts than is indicated in some of the records.

As remarked above, however, the pathology of the condition, quite apart from the difficulties of its diagnosis, must always leave it with a formidable mortality.

#### REFERENCE.

COKKINIS.—*Mesenteric Vascular Occlusion*, Baillière, Tindall & Cox, 1926.

ALEX. E. ROCHE.

#### NOTES ON NURSING, WITH SPECIAL REFERENCE TO THE NURSING OF FRACTURES OF THE FEMUR AND THE VERTEBRAL COLUMN.



FROM a nursing point of view the main principle of fracture treatment should be *absolute immobilization* of the injured part and of any structure associated with it. It is a pity there is not in this Hospital a "fracture ward," where fractures could be treated and nursed with the care and respect that they merit.

Instead of this one sees the following things:

(a) A case of fractured femur is *lifted* up by the pelvis in order to reach the buttocks and lumbar region.

(b) A fractured spine is *rolled* over on to his side in order to powder his back; or again his pelvis is raised up for certain necessary reasons.

(c) The bed is moved or jolted in bed-making.

(d) In cases of fractured femur the patient attempts to lessen the extension by propping a pillow under his shoulders and head and pushing against the head end of the bed.

(e) The instability of the antiquated Balkan frame.

This lifting and movement of the patient produces displacement of the fragments, straining of the callus, and *pain*. Anyone who has had a fracture and has had it inadvertently moved every day knows what this pain is like and how long it lasts. In the case of fractures of the vertebral column there is an added risk of producing paraplegia or diplegia.

The solution of this problem of maintaining absolute immobilization is to devise a bed which will enable this important principle to be carried out, and at the same time allow free access for the necessary nursing. Below are appended two rough diagrams of an apparatus that, although not complete in technical and mechanical detail, would allow these principles to be carried out. Incidentally I might mention here that three months ago a patient of mine required a "divided mattress," and there was no such thing in the whole Hospital.

#### Description of Bed (see Diagrams).

The bed consists of a framework, a canvas sheet (upper view shown in Diagram A), and a mattress which can be raised to approximate the canvas sheet and lowered away from it in order to give a space for nursing manipulations (see Diagram B).

(1) (See Diagram A). The sheet consists of canvas covered by a thin layer of white sheet rubber, the latter being firmly stuck to the canvas.

Around the borders of this canvas sheet are a series of perforations circumferenced by a metal ring. Through these perforations cord is passed and attached to the framework.

*a* and *a'* is an air ring and cushion incorporated in the

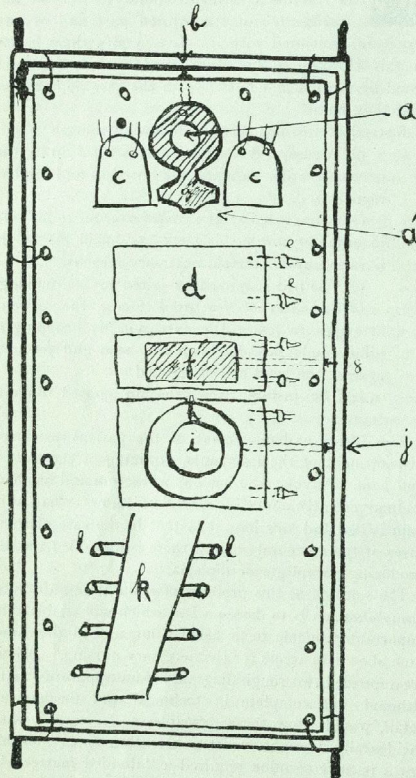


DIAGRAM A.

canvas sheet, and which can be inflated with air by attaching a bicycle pump to the tap *b*.

The head rests in the ring and the air-cushion fills the concavity of the posterior cervical region.

*c, c* are shoulder slings that can be attached to the frame at the foot of the bed and so prevent the patient slipping if the framework is tilted with the feet raised, as in fractured femurs.

*d* is a window of canvas which can be opened by

undoing the strap and buckle at *e* on the *under* surface of the sheet.

*f* is a similar canvas window, only with an air cushion incorporated in it for the purpose of filling the "lumbar hollow." It can be inflated from the tap *g*.

*h* is another modified window in which is incorporated an air ring. The centre part, *i*, can be undone and turned back separately. In cases of incontinence this can be utilized, a tray of charcoal or other deodorizer and absorptive agent being placed in this space.

This would save the constant changing of the soiled sheets and bedding, etc., and at the same time would leave the patient undisturbed.

*j* is a tap for inflating the air-ring. All the straps, buckles, air-feed tubes, etc., are on the *under* surfaces of the sheet and away to the side of the patient.

*k* is a canvas sling for the lower limb. It can be detached from the sheet. The use of it would obviate the need for a Thomas's splint, as the limb could be slung in it by fixing cords through the rings *l*, and attaching them to an overhead beam. Extension could be applied directly to the limb.

A similar sling could be attached to the sheet on the opposite side.

(2) Diagram B is a general view of the bed. The patient is lying on the canvas sheet.

*m* is the mattress, which can be elevated or lowered by the handle *n*.

*o* is a handle to elevate the foot of the framework and thereby tilt the patient.

The framework could also be fitted with an overhead beam, crossbars and pulleys for abduction and extension of the lower extremities.

The bed can be moved on castors. The diagrams make no attempt at mechanical correctness.

*Nursing.*—Once in position the patient is left *immobilized*. Further restraint on movement could be adopted by passing strips of canvas over the pelvis and thorax and lacing them to the framework.

The air-cushions are inflated the necessary amount, and the mattress *m* approximated to the *under-surface* of the canvas sheet and the bed-clothes tucked in under the mattress.

For washing the back, rubbing and powdering, etc., untuck the bedclothes and fold each side toward the mid-line, keeping the patient covered up. Lower the mattress about 1½-2 ft. Undo the canvas windows one at a time, and strap up again before undoing the next one.

The canvas sheet does not crease, and can be easily cleaned by sponging the rubber surface.

If the patient is incontinent undo the window *i* and place a circular tray in the space provided. The tray

can be filled with charcoal, etc., and can be removed from time to time. There is no excuse for interfering with any of the retentive or extensive apparatus.

I have not had sufficient time to make a thorough study of nursing manuals, so I do not know whether this design of bed is original or not.

#### Rectal Salines

Great loss of time and discomfort to patient and nurse are brought about by the somewhat antiquated way of delivering post-operative salines.

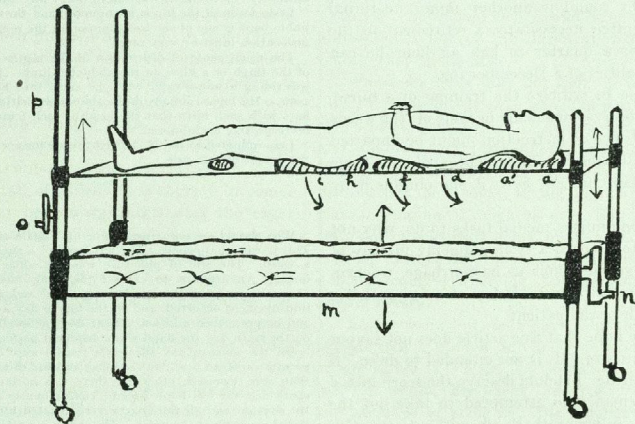


DIAGRAM B.

From a Souttar's thermos-flask apparatus fluid can be run in at a constant temperature and the amount carefully regulated. This would save a nurse from solemnly sitting down for half an hour and holding a dilapidated glass funnel until her arm aches, and would also leave her free to watch the patient's general condition.

#### The Administration of Narcotics.

Whether through pressure of work or lack of imagination, the administration of a narcotic is only too often delayed. The patient wants relief from his pain as soon as possible.

#### Asepsis.

Some re-adjustment in the theatre staff-work is necessary. The sister or nurse in charge of the case, after having put on a sterile gown, is subjected to serious risks by having to wait outside the theatre whilst the case is being anaesthetized. The chances of her gown

being touched by some part of the stretcher or its coverings, the anaesthetic apparatus, or anyone passing near her, are considerable. The time allowed her for washing up is that taken up by the arranging of the patient on the table—some three to five minutes at the most. The experts tell us that it takes 15 minutes of washing to make the hands reasonably sterile.

Masks should always be worn and the hair *completely* covered. If such precautions are not taken the swabs, packs, dressings, etc., are in danger of receiving a shower of micro organisms.

#### Night Superintendents.

When a night nurse is faced with a surgical emergency in the form of a haemorrhage, asphyxia, etc., the present routine is as follows: The nurse summons her junior colleague, a "probationer," and leaves the latter in charge of the case whilst she goes to the telephone *outside* the ward and attempts to get into touch with the Night Superintendent and inform her about the case. The Night Superintendent then comes to the ward to see the case and to decide whether the House Surgeon shall be sent for. Meanwhile, during some 5 to 7 minutes, the "probationer" has had to deal with the case. In some instances she does what she can very well, but in others she is too scared to do anything at all.

I had a case of haemorrhage from the floor of the mouth in which the patient bled freely for some 10 minutes or more before I received a message to go to the ward. This was entirely due to this absurd routine—a sluggish telephone exchange, a frightened, restless patient and a still more terrified "probationer." When I reached

the ward I had to apply digital pressure for 10 to 15 minutes whilst a light, plugging, ligatures and needles were being collected.

Would it not be better for the senior nurse to render first aid, for the "probationer" to go to the telephone and ring for the House Surgeon, then return to the ward and get the necessary instruments ready for the House Surgeon, and then, after that, phone for the Night Superintendent?

The strange custom of a House Surgeon not being allowed to meet a Night Superintendent in his own ward whilst on a night round is another minor nocturnal irritation, which often necessitates a retirement to the Square, where for a quarter to half an hour he can ponder on the qualities of a December fog.

It is not for me to criticize the training of a nurse, but from casual observations made in some of the wards I feel that a great deal of instruction might be imparted in a more congenial fashion. The reception of knowledge should be a pleasant process, even if one obtains it by making a mistake.

Instead of giving nurses menial tasks to do, why not drill them daily to prepare a trolley quickly for any of the surgical emergencies, such as hæmorrhage, tracheotomy, etc., and time them? Delay of a few minutes often means death to the patient.

It is my sincere hope that this article does not savour of destructive criticism. It is not intended to do so. If I ventured any further I should deserve the scorn meted out to the gentleman who attempted to take out the "mote" that was in his brother's eye without attending to the "beams" that were in his own eye.

My purpose in writing this article is to point out a few nursing details which I believe would make for the comfort of the patient, the efficiency of the treatment, and at the same time would stimulate nurses to think about such problems as the construction of mechanized beds and other improvements in ward hygiene, the introduction of which would save them from some of those irksome and unpleasant tasks that add to their daily burden in the wards. H. B. STALLARD.

## ANNOTATIONS.

### BILATERAL PUBIC DISLOCATION OF THE HIP.

A man, æt. 36, was brought by ambulance to the Royal South Haunts and Southampton Hospital two hours after a motor accident. The position of his lower limbs was such that he could not balance himself upon an ordinary stretcher, but had to be carried into the hospital lying on a door. Both thighs were flexed, abducted and rotated outwards. They were fixed in this position, and any attempts at movement or removal of his clothes to facilitate examination caused very severe pain.

The patient, still lying on the door, was placed on the floor of the

anæsthetic room and a general anæsthetic was administered. It was then possible to remove his boots and trousers and to make a more thorough examination. The head of each femur was felt lying above and behind Poupert's ligament, to the outer side of the femoral vessels.

Both dislocations were easily reduced by the method of first increasing and then correcting the deformity. The pelvis was steadied by an assistant, and the movements were as follows:

1. Increased abduction, external rotation and flexion.
2. Adduction, internal rotation and extension.

A jerk was felt in each limb on completion of the second manœuvre. The patient's legs were tied together and he was taken to the ward, where he remained in bed for four weeks. A skiagram taken the day after reduction showed no displacement or fracture of the bones. Massage was begun on the third day, and passive movements on the sixth. Ten weeks after the injury there was no sign of disability. Movement was full in every direction and painless.

Dislocation of the hip is uncommon, and the dislocation on to the pubic bone is one of the less common of the regular type. Bilateral dislocation must be very rare.

The usual cause of dislocation of the hip is a forcible abduction of the thigh or a blow on the abducted limb. In this case the man was riding a motor-cycle when he came into head on collision with a car. His knees, already in the abducted position, struck the handle bars with such force that the head of each femur was forced out of its respective acetabulum.

I am indebted to Dr. H. J. Nightingale for permission to reproduce the details of this case.

### A WASP STING.

Why should a wasp sting "come up" again after it has subsided? This is what happened. The left hand of a small boy was stung by a wasp. The site of puncture was the ulnar side of the middle finger. An attempt to extract the sting was deemed successful. The same evening the hand was painful and greatly swollen. No improvement occurred, and on the fourth day a doctor was called in and he prescribed a lotion. Next day the swelling went down, and on the sixth day the hand was considered perfectly well.

On the seventh day the boy's tonsils were nucleated, his temperature rose to 100° that evening and his throat was more painful than was expected, otherwise there was nothing of note. On the ninth day the left hand became conspicuously swollen. The palm, the dorsum and all the fingers were affected by the swelling, which ended abruptly at the wrist. The skin was uniformly pale and movement of the fingers was restricted. The boy complained of an itching or irritation which kept him awake, but said it was not painful.

On the tenth day the swelling gradually disappeared and nothing more was seen of it.

Is such a sequence of events to be expected? Perhaps those who are in the habit of operating on boys stung by wasps will tell us. In any case an elucidation by a pathologist would be welcome.

FRANK ROSE.

### A PRE-ANÆSTHETIC OPERATION.

It has been suggested to us by a member of the Staff that the following quotation from Dr. John Brown's *Rab and His Friends* would be of interest as a graphic description of a once common though now scarcely imaginable occurrence.

"Next day my master, the surgeon, examined Ailie. There was no doubt it must kill her, and soon. It could be removed—it might never return—it would give her speedy relief—she should have it done. She curtsied, looked at James, and said, 'When?' 'Tomorrow,' said the kind surgeon, a man of few words. She and James and Rab and I retired. I noticed that

he and she spoke little, but seemed to anticipate everything in each other. The following day, at noon, the students came in, hurrying up the great stair. At the first landing-place, on a small well-known black board, was a bit of paper fastened by wafers, and many remains of old wafers beside it. On the paper were the words, 'An operation to-day. J. B. Clerk.'

"Up ran the youths, eager to secure good places: in they crowded, full of interest and talk. 'What's the case?' 'Which side is it?'

"Don't think them heartless; they are neither better nor worse than you or I: they get over their professional horrors, and into their proper work; and in them pity—as an *emotion*, ending in itself or at best in tears and a long-drawn breath, lessens, while pity as a  *motive*, is quickened, and gains power and purpose. It is well for poor human nature that it is so.

"The operating theatre is crowded; much talk and fuss, and all the cordiality and stir of youth. The surgeon with his staff of assistants is there. In comes Ailie: one look at her quiets and abates the eager students. That beautiful old woman is too much for them; they sit down, and are dumb, and gaze at her. These rough boys feel the power of her presence. She walks in quickly, but without haste; dressed in her mutch, her neckerchief, her white dimity shortgown, her black bombazeen petticoat, showing her white worsted stockings and her carpet-shoes. Behind her was James with Rab. James sat down in the distance, and took that huge and noble head between his knees. Rab looked perplexed and dangerous; for ever cocking his ear and dropping it as fast.

"Ailie stepped up on a seat, and laid herself on the table, as her friend the surgeon told her; arranged herself, gave a rapid look at James, shut her eyes, rested herself on me, and took my hand. The operation was at once begun; it was necessarily slow; and chloroform—one of God's best gifts to his suffering children—was then unknown. The surgeon did his work. The pale face showed its pain, but was still and silent. Rab's soul was working within him; he saw that something strange was going on—blood flowing from his mistress, and she suffering; his ragged ear was up, and impertunate; he growled and gave now and then a sharp impatient yelp; he would have liked to have done something to that man. But James had him firm, and gave him a glower from time to time, and an intimation of a possible kick—all the better for James, it kept his eye and his mind off Ailie.

"It is over: she is dressed, steps gently and decently down from the table, looks for James; then, turning to the surgeon and the students, she curtsies—and in a low clear voice, begs their pardon if she has behaved ill.


The students—all of us—wept like children; the surgeon happened her up carefully—and, resting on James and me, Ailie went to her room, Rab following. We put her to bed. James took off his heavy shoes, crammed with tackets, heel-capt and toe-capt, and put them carefully under the table, saying, 'Maister John, I'm for nane o' yer stryngie nurse bodies for Ailie. I'll be her nurse, and on my stockin' soles I'll gang about as canny as pussy.' And so he did; and handy and clever, and swift and tender as any woman, was that horny-handed, snell, peremptory little man. Everything she got he gave her: he seldom slept; and often I saw his small, shrewd eyes out of the darkness, fixed on her. As before, they spoke little.

"For some days Ailie did well. The wound healed 'by the first intention'; as James said, 'Oor Ailie's skin's over clean to beil.' The students came in quiet and anxious, and surrounded her bed. She said she liked to see their young, honest faces. The surgeon dressed her, and spoke to her in his own short kind way, pitying her through his eyes, Rab and James outside the circle—Rab being now reconciled, and even cordial, and having made up his mind that as yet nobody required worrying, but, as you may suppose, *semper paratus*.

"So far well—but, four days after the operation, my patient had a sudden and long shivering, a 'groofin', as she called it. I saw her soon after; her eyes were less too bright, her cheek coloured; she was restless, and ashamed of being so; the balance was lost; mischief had begun. On looking at the wound, a blush of red told the secret: her pulse was rapid, her breathing anxious and quick, she wasn't herself, as she said, and was vexed at her restlessness. We tried what we could. James did everything, was everywhere; never in the way, never out of it; Rab subsided under the table into a dark place, and was motionless, all but his eye, which followed everyone. Ailie got worse; began to wander in her mind, gently; was more demonstrative in her ways to James, rapid in her questions, and sharp at times. He was vexed, and said, 'She was never that way afore; no, never.' For a time she knew her head was wrong, and was always asking our pardon—the dear, gentle old woman: then delirium set in strong, without pause."

## THE ABC OF VITAMINS.

## A.

 H fine and fat was Ralph the rat,  
And his eye was a clear cold grey.  
How mournful that he ate less fat  
As day succeeded day,  
Till he found each cornea daily hornier,  
Lacking its Vitamin A.  
"I missed my Vitamin A, my dears,"  
That rat was heard to say,  
"And you'll find your eyes will keratinize  
If you miss your Vitamin A."

## B.

Now polished rice is extremely nice  
At a high suburban tea,  
But Arbuthnot Lane remarks with pain  
That it lacks all Vitamin B,  
And beri-beri is very very  
Hard on the nerves, says he.  
"Oh take your Vitamin B, my dears!"  
I heard that surgeon say;  
"If I hadn't been fed on standard bread,  
I shouldn't be here to-day."

## C.

The scurvy flew through the schooner's crew  
As they sailed on an Arctic sea.  
They were far from land and their food was canned,  
So they got no Vitamin C,  
For "Devil's the use of orange juice"  
The skipper 'ad said, said he.  
They were vidualled with pickled pork, my  
dears,  
Those mariners bold and free,  
Yet life's but brief on the best corned beef  
If you don't get Vitamin C.

## D.


The epiphyses of Gemima's knees  
Were a truly appalling sight;  
For the rickets strikes whom it jolly well likes  
If the Vitamin D's not right,  
Though its plots we foil with our cod-liver oil  
Or our ultra-violet light.  
So swallow your cod-liver oil, my dears,  
And bonny big babes you'll be.  
Though it makes you sick it's a cure for the  
rickets  
And teeming with Vitamin D.

## E.

Now Vitamins D and A, B and C  
Will ensure that you're happy and strong;  
But that's no use; you must reproduce  
Or the race won't last for long.  
So Vitamin E is the stuff for me,  
And its praises end my song.  
We'll double the birth-rate yet, my dears,  
If we all eat Vitamin E.  
We can blast the hopes of Maria Stopes  
By taking it with our tea.  
C. H. A.

## DESCANTS OF THE DISTRICT—I.

(With apologies to Good King Wenceslas.)

 ISTRICT Number One awoke  
From the land of dreaming;  
Trumpet-toned the porter spoke,  
And his breath rose steaming:  
"Distric' letter just arrived  
From the New North Road, sir;  
Snow is falling fast and wide  
And it's mighty cold, sir"

Bring my bag and bring my drum,  
Bring my coat of leather.  
I will sip a sup of rum  
Ere I brave this weather  
Bravely flowed the golden flood,  
And the clerk sang gladly,  
Till he felt his heated blood  
Flowing round him madly.

Now the anxious father spoke,  
With his hands entreating:  
'Sir, the waters all is broke,  
And the time is fleeting."  
Clerk and parent forth they went,  
Long their shadows falling,  
While the clerk the echoes rent,  
Loud his descant bawling.

Gently was the infant born,  
No apparent hitches;  
Perinæum slightly torn,  
Well secured by stitches.  
Full the flowing bowl they fill,  
And their praise falls thicker,  
Lauding Bart.'s obstetric skill,  
Reinforced by liquor.

Here the clerk his face was red,  
And his brain was hazy;  
Left placenta in the bed,  
Packing up the baby.  
Hearing not its feeble fuss,  
Lying in the Fountain;  
There it formed the nucleus  
Of a snowy mountain.

Christmas Day in Dartmoor Gaol,  
See the convicts dining.  
Woeful is the clerk and pale,  
Still for home repining.  
Therefore all who love good cheer,  
Be it rum or better,  
Take no more than ginger-beer  
On a District Letter.

F. W. J. W.

## STUDENTS' UNION.

## DEBATING SOCIETY.

A MEETING of the St. Bartholomew's Hospital Debating Society was held in the Abernethian Room on Thursday, December 15th, 1927, Dr. E. R. CULLINAN in the Chair.

*Motion:* "That contraception should be taught to wider circles."  
Mr. A. W. FRANKLIN, proposing the motion, said it was no use denying the practice of birth control. A certain clinic in London received inquiries from all over England, and indeed further afield than that. It was the Mecca of wise parents. It presented a problem for the medical profession, who must choose one of three possibilities: (1) To legalize it—a useless procedure, (2) do nothing—the result of which would be equivalent to teaching it; (3) to teach it.

It was a scandal in itself that a dirty and unshaven man could beg in the street for money to keep his wife and five children. Such a man was being kept by the State, and better stock were not having children in order to subsidize those of this man. The nation was breeding from its poorest stock and the birth rate in this part of the community should be lowered. There were five ways of doing this: coltus interruptus, exposure of infants and abortion, which were harmful to the individuals concerned, and moral restraint and contraception. The former of these was shown to be no earthly use. It was of theoretical rather than practical importance. Contraception was left as the only possible solution.

Mr. P. ROWNSOXE opposed the motion by a speech which aroused much humour. He was a supporter of the practice of birth control, but strongly opposed its wider advocacy at the present time. The promiscuous teaching of birth control was not for the well-being of the public. It would increase immorality. He would give the medical profession much more power in the matter. Each case should be judged on its merits by a competent body, and if of a suitable nature, materials and appliances should be given to the individual. The law should make it impossible to get appliances except on the instruction of a medical man.

Mr. F. G. V. SCOVELL, in supporting the motion, developed a clear and logical argument that as civilization had advanced, so natural functions had become modified. Wars killed fewer people than in the past. The aim of the medical profession was to prolong life, as well as to raise the standard of life. These factors tending to increase population needed a counter-weight. This need was supplied by contraception, which was the only civilized method of reducing population.

Mr. A. SUGDEN, in supporting the opposition, said that man was

only a part of the animal kingdom, and unless he continued to improve he would be overcome by other forms of life. The wider teaching of contraception would lower the vitality of the human race and would have disastrous results.

Mr. L. HOLMES strongly supported the motion on account of his experiences on "District." Smaller families would be advantageous in many homes. He denied that contraception had harmful results, which was the case from abortion, which was the only other alternative.

Mr. J. W. O. FREETH said that wider teaching did not mean wider practice of birth control. There would be an increased differential birth-rate between skilled and unskilled workmen.

Mr. E. S. EVANS thought that the father of a family was asked to exercise an impossible restraint. Wider teaching of birth control would lead to less immorality. Appliances should be given to women, but the State should have the right to insist on their use in certain cases.

Dr. E. R. CULLINAN thought that the proposers were advocating a short-sighted policy. Contraception is practised in the upper classes with undesirable results. There was a tendency to give one's children a good education. If the idea caught on there would soon be no workers to produce food and other necessities of life. Superfluous population could be sent to the Colonies.

Dr. J. MAXWELL, supporting the motion, desired to lay more stress on the ethical and religious sides, as well as on that of expediency. The point of view of the child ought to be considered. Small incomes should mean small families. In large, poor families, 50% of the children were unhealthy.

Mr. BEDDARD said that as contraception was voluntary, there was no certainty about it. He would advocate sterilization of the unfit.

Mr. BURT-WHITE spoke of the effects of repeated pregnancies. Women were damaged and their health ruined, so that they became unattractive machines for producing children. People who practise moral restraint to an unnatural extent become morose and bad-tempered. The finding of a recent Royal Commission was that modern contraceptive methods produced no harmful results.

Mr. J. O. WILLIAMS thought that no harm could result from contraception.

The opposer and proposer then summed up for their respective sides, and a division was taken, the motion being carried by 72 votes to 9.

## RUGBY FOOTBALL CLUB.

## ST. BARTHOLOMEW'S HOSPITAL v. BRISTOL.

On November 20th, at Bristol. For this game Bristol had out their "strongest side of the season," Corbett and Locke, last year's England centres, turning out together for the first time. The Hospital were at full strength forward, but were without Guinness, Beilly and Drowse outside the scrum. The conditions were bad, the ground being very soft, while it rained throughout the match. At the start our forwards, aided by Gaisford's kicking, kept play in Bristol's half, but Thompson getting offside in a forward rush, Howe kicked a very good penalty goal for our opponents. A few minutes later Corbett made an opening for Lilliecap to score wide out. The Hospital had most of the play for the rest of the half, and Rowe broke away well on one occasion, but his pass went astray.

In the second half Bristol tried to open up the game, but without success, and play was for the most part confined to their half of the field. Our forwards continued to have most of the game, but one lapse in marking at the line-out allowed Shaw to break away and lead up to another try, Bristol thus winning by a penalty goal and two tries (9 pts.) to nil.

The Hospital forwards played exceptionally well, being equal to the Bristol pack in nearly every phase of the game and superior in the line-out, except for the one lapse mentioned above, and loose scrums; we were, however, unable to get much of the ball in the light, where Tucker and Shaw were too clever for us. Taylor again did well at scrum-half, being in no way inferior to Carter. Owing to the appalling conditions the backs did not have a happy time, but they bottled up the Bristol centres well. Gaisford's fielding and kicking were up to his best form, and he saved a certain try when he tackled Lilliecap when the latter was going all out for the line. Mr. Scorer, of Birmingham, refereed admirably.

*Team:* W. F. Gaisford (capt.), A. H. Grace, G. F. Potts, J. T. Rowe, J. D. Powell (three-quarters); E. U. H. Pentroath, J. T. Taylor (halves); R. N. Williams (capt.), C. R. Jenkins, R. H. Bettington

H. D. Robertson, G. D. S. Briggs, W. M. Caffer, V. C. Thompson, H. G. Edwards (*forwards*).

#### ST. BARTHOLOMEW'S HOSPITAL v. DEVONPORT SERVICES.

On November 26th, away. The Hospital were without Gaisford and Rettington, while the Services' captain, Surg.-Lieut. Osburne, was unable to play owing to an injury. The game started with the Services attacking, and with the Hospital failing to get together we passed an anxious ten minutes. Our defence held, however, and we then began to settle down. Prowse and Guinness were combining well and only sound tackling kept them out on two occasions. Briggs then broke through, but lost a certain try by kicking ahead when he had three forwards up with him. Just before half-time Guinness cut in and put Thompson over near the posts, Gaisford converting.

The second half opened in a sensational manner. Gaisford kicked off, exploiting the long kick, and with the Services' full back fumbling the ball, the Hospital wing forwards were upon him and Briggs scored in the corner, the difficult kick failing. Play now became very keen, and eventually the Services scored through Petty missing his man, the try being converted. The Bart.'s forwards then dribbled back to the Services' line, and heeled quickly from a loose scrum, Guinness dropping a good goal. Play was even for the remaining twelve minutes, and the Hospital were left winners of a good game by 2 goals (1 dropped) and a try to a goal (12 pts. to 5).

The Hospitals backs gave an excellent account of themselves, Beilly, Guinness and Prowse proving themselves a thrustful attacking force. Gaisford was again at the top of his form and saved his forwards a great deal, and Taylor played a sound game. The forwards were very good in the loose, but Bettington was missed in the tight, for we often got the ball, but were pushed off it.

*Team:* W. F. Gaisford (*back*); E. U. H. Pentreath, G. F. Petty, H. W. Guinness, C. B. Prowse (*three-quarters*); F. J. Beilly, J. T. Taylor (*halves*); R. N. Williams (capt.), C. R. Jenkins, H. D. Robertson, G. D. S. Briggs, W. M. Caffer, V. C. Thompson, H. G. Edwards, W. J. Taylor (*forwards*).

#### ST. BARTHOLOMEW'S HOSPITAL v. R.N.E.C. (Keyham).

On November 28th. The excellent conditions we had enjoyed on Saturday did not last and this game was played in pouring rain on a sea of mud. Knox came into the side instead of Caffer, and Powell played on the wing, Prowse moving in to the centre instead of Guinness. The first half consisted of forward rushes by both sides, but neither line was ever seriously in danger and half-time came with no score. Early in the second half Keyham scored from a three-quarter movement, following a clean heel from a scrum under the posts. The Hospital then attacked hotly and Keyham had to touch down four times in quick succession. Just before the end the College scrum half got over from a line-out on our line, this try being due to a careless throw by our wing, for with the forwards bunched up close, he threw out a long pass. This try was converted, and soon after "no-side" was blown.

This game was mostly confined to the forwards, both packs going all out and there being very little between them; our forwards, however, played a great deal below their form of two days before, and were inferior to their opponents in combined dribbling. The backs on both sides spent the afternoon stopping forward rushes and attempting to field the greasy ball from punts ahead. The sticky ground caused both Beilly and Thompson to twist their knees—a heavy loss.

Our thanks are due to the Services, especially Surg.-Lieut. Osburne, and to the Keyham team for the most enjoyable time they gave us during our stay. The two events which stand out are a trip over one of the latest submarines, and a drive over Dartmoor on the Sunday afternoon.

#### ST. BARTHOLOMEW'S HOSPITAL v. GLOUCESTER.

On December 10th, at Gloucester. For this match we were without Caffer in the pack and Beilly and Grace in the backs. We started off well and Rowe nearly scored, but was forced into the corner-flag. Gloucester then worked the ball into our "25" and play settled on our line for some time, Gloucester eventually scoring on the blind side. Just before half-time they broke through the centre and scored again. Our opponents scored twice early in the second half, the 1st try being converted. Both these tries were due to extraordinarily bad tackling on the part of our backs. Play was even for the remainder of the game, Rowe still failing to get over before the end. Gloucester, 1 goal 3 tries (14 pts.), Bart.'s nil.

Our team were right off form in this match, particularly in the back division, where Gaisford and Prowse were the only two who played up to anything like their usual form. There was no finish in the attacking movements and the passing was deplorable, while we presented our opponents with three tries by bad tackling. The forwards were not up to their usual standard, although we got the ball in the scrum a great deal more than our opponents. Thompson was unfortunate enough to damage his knee again early in the second half.

*Team:* W. F. Gaisford (*back*); E. U. H. Pentreath, G. F. Petty, J. T. Rowe, C. B. Prowse (*three-quarters*); H. W. Guinness, J. T. Taylor (*halves*); R. N. Williams (capt.), C. R. Jenkins, R. H. Bettington, H. D. Robertson, G. D. S. Briggs, V. C. Thompson, H. G. Edwards, F. G. V. Scovell (*forwards*).

#### HOCKEY CLUB.

##### ST. BARTHOLOMEW'S HOSPITAL v. ROYAL NAVAL COLLEGE, GREENWICH.

December 3rd. The R.N.C. have a very strong, fast side, and at Greenwich we sustained our first real defeat of the season. Perhaps we were unfortunate in not scoring in the first half; we forced several corners and twice only missed scoring through ill-fortune. The R.N.C. thoroughly deserved to win, their superiority lay not so much in their skill as in their speed and good training.

The game opened with several dangerous attacks on our goal. Windle was tested, but was not very sure in his clearing; the ball rebounded from his pads after a hard shot and one of the insides immediately put it into the net. The St. Bart.'s play was rather scrappy after this and several fouls were given against them, especially for "sticks." The Greenwich outside right got right away down the wing and sent across a centre that the inside right drove into the net with a first-time shot. St. Bart.'s now began to play up twice strongly; the forwards got the ball into the R.N.C. circle and sent in several shots, but without success.

The second half opened with the score at 2-0, and it was in this half that our opponents' superior training and speed really began to tell. They repeatedly rushed our goal, beating the half-backs and backs by their speed and long through passes. From one of these attacks they added their third goal. Shortly after they forced a corner, and the inside left scored with a beautiful drive. Our forwards were often getting the ball up the field, but the R.N.C. backs were a very strong pair and broke up every attack. Just before the whistle blew the R.N.C. added their fifth goal.

McCay played a great game at left back and he showed fine anticipation in stopping our opponents' passes. The redeeming feature of the team was the fine play of Fordham and Williams on the left wing; Fordham held his outside very well and Williams sent across many good centres.

*Team:* R. W. Windle (*goal*); P. M. Wright, F. H. McCay (*backs*); M. S. M. Fordham, W. F. Church, J. H. Attwood (*halves*); A. C. Williams, R. H. Francis, K. W. D. Hartley, J. W. C. Symonds, M. R. Sinclair (*forwards*).

##### ST. BARTHOLOMEW'S HOSPITAL v. HORNSEY.

November 10th. This match was played under very bad conditions: it rained the whole time, and before the game had finished the ground was like a mire in many places. Two of the first eleven were away: Snell took the place of Fordham at left half and Roberts played inside left in the place of Francis. The match was not so one-sided as the score of 12-0 would suggest. Hornsey gave us quite a good game. We were superior in every department of the game, but it was our hard hitting tactics that gave us the double figures.

Goals came pretty fast in the first half and still faster in the second half. Williams and Sinclair were in great form on the two wings; Sinclair sent across centres that put fear not only into the Hornsey attack, but also our insides. The half-backs kept the Hornsey forwards well under control; the backs and goalie had little to do. Snell at left half gave Williams many good passes and shows distinct promise. Goals were scored by Hartley (5), Williams (2), Sinclair (2), Symonds (2), Church (1).

*Team:* R. Windle (*goal*); F. H. McCay, P. M. Wright (*backs*); V. C. Snell, W. F. Church, J. H. Attwood (*halves*); A. G. Williams, Roberts, K. W. D. Hartley, J. W. C. Symonds, M. R. Sinclair (*forwards*).

## CORRESPONDENCE.

### THE CHRISTIAN UNION.

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

DEAR SIR,—May I bring before your readers again the activities of the Christian Union? We have had much encouragement during the past term, and the week of special meetings, November 21st-25th was the largest effort which the L.L.F.C.U. has so far put forth. Between 450 and 500 students came to the Great Hall to hear Mr. Kendle Short and Sir Thomas Inskip.

We are arranging a list of attractive speakers for our weekly meetings next term, and may I especially draw attention to the meeting on March 1st, when Mr. Bacon has promised to come and speak on "Is Real Peace of Mind Possible?"

We are sure that in these days of controversy the simple testimonies given week by week in the Library are invaluable. We seek in these meetings to emphasize the certainty of Eternal Truths, and the complete satisfaction which is found in the Lord Jesus Christ alone.

Believe me,  
Yours truly,  
J. W. C. SYMONDS,  
Hon. Sec.

St. Bartholomew's Hospital,  
London, E.C. 1;  
December 20th, 1927.

### THE DEBATING SOCIETY

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

DEAR SIR,—At a General Meeting of the Debating Society held in the Abernethian Room on December 1st, the following officers were elected: President, Sir Thomas Horder, Bart.; Vice-Presidents, Dr. E. R. Cullinan, Mr. R. W. Raven; Hon. Sec., Mr. J. W. O. Freeth; Committee, Mr. P. Robinson, Mr. J. Lawn, Mr. I. W. Matheson.

I should like to point out that all members of the Students' Union are *ipso facto* members of the Debating Society, and whether they are freshmen or qualified men, they will be welcomed at its meetings.

I am,  
Yours faithfully,  
J. W. O. FREETH,  
Hon. Sec.

St. Bartholomew's Hospital,  
London, E.C. 1;  
December 20th, 1927.

### A CORRECTION.

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

DEAR SIR,—I did not know that my writing was so illegible when signing my letter *re* the Old Students' Dinner. I trust that you can rectify the mistake.

Yours faithfully,  
R. MURRAY BARROW.

Long Sutton,  
Wishbech;  
December 10th, 1927.

[We offer our sincere apologies to Dr. Murray Barrow for the gross misprinting of his name in our last issue.—ED., ST. B. H. J.]

### READERS' OPINIONS.

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

DEAR SIR.—Mr. Leitch's letter of last month, appearing in the series headed "Readers' Opinions," moves me to offer one or two criticisms.

I confess at the outset that I feel at a disadvantage. The odium with which many regard indulgence in public letter-writing arises from the ease with which a dignified correspondence may become vulgar. Hence my doubt of the propriety of joining this controversy, for one of my criticisms is that Mr. Leitch has lapsed gravely from dignity and taste. Both W. K. P. and a Subscriber referred to

M.'s writing in terms applicable to writing, which, for example, can be reasonably called cynical, menacing or light-minded. "Garbage," however, being mere metaphor, is neither nice nor critical. It is unsavoury abuse of a sort Mr. Leitch himself would rightly scorn were he not carried away by his concern for the integrity of Heaven and Hell, Time and Eternity.

This brings me to my second criticism. W. K. P.'s original accusations were not substantiated except in two rather unimportant instances. A Subscriber and Mr. Leitch both seize upon what was very incidental in those accusations, namely, M.'s irreligion. None of them has indicated it, and the argument is now centred round a matter of doubtful authenticity.

But however well these attacks have been repudiated by M., they are the smoke of a real fire. M. displays (harmless enough) a levity combined with intolerance, and a trace (M. will pardon me if I am in error) of intellectual snobbery, which I, for one, find irritating, and declare ill advised, in controversial letters. There, I think, lies the root of the trouble. None of us like to be patronized, and it is human to voice our disapproval under the impersonal guise of solicitude for the welfare of the JOURNAL. I plead no such excuse, for the JOURNAL seems capable of looking after itself. I write in the hope of bringing *paux hominibus bonae voluntatis*. I trust I have maintained an attitude sufficiently detached to merit the signature of

Yours faithfully,  
E. LEITCH.

December 15th, 1927.

## REVIEWS.

THE ENDOCRINES IN GENERAL MEDICINE. By LANGDON BROWN, M.A., M.D., F.R.C.P. (London: Constable & Co., Ltd., 1927.) Pp. 144. Price 7s. 6d. net.

Dr. Langdon Brown's monograph is one to which the term "fascinating" may justly be applied. We commend it to those persons—usually retired house surgeons—who find medicine "dull"; if it does not stimulate their interest in the subject, nothing will do so!

But it is written for, and must appeal to a wider public than this. Dr. Langdon Brown states in his preface that he hopes the book may be "of service to the general practitioner." We venture to think that it is exactly the sort of book which the general practitioner wants; though it should be equally useful to the consultant.

In the first chapter the endocrines are dealt with from their biological standpoint, and theory is blended with morphological fact in an attractive manner. The subsequent chapters deal with the clinical pictures resulting from endocrine disturbance at various times of life. Here statement of conclusion is generously interspersed with descriptions of illustrative cases. This has the great advantage of "fixing" the conditions in the reader's mind by an introduction of the "personal" factors. A useful chapter is devoted to endocrine therapy; this should particularly appeal to the general practitioner, whose cry is, not unnaturally, "What about treatment?" Copious references are given throughout the book, which will enable those specially interested in any of the subjects described to lay hands upon the literature. It is perhaps a pity that the book lacks pictorial illustrations. If we cannot see all the interesting cases described, we should at least like to see their photographs. That is the only improvement we can suggest in a really delightful work.

GUY'S HOSPITAL REPORTS (Vol. 77), Nos. 3 and 4. Bright Centenary Number. Price 2s. net.

The centenary of Richard Bright has been fitly celebrated, both in deed and, as this report shows, upon paper. Little more can be done in a short review than to indicate the contents of the Report. The majority of the articles deal directly with various aspects of Bright's disease; Dr. Thayer, Dr. Eason and Dr. Kyle contribute to the historical survey of the work of Bright and his successors. Prof. Aschoff writes on disorders of the kidney with symptoms of Bright's disease; Prof. Lerner on the syndromes in nephritis. Sir John Bradford writes upon uraemia; Dr. Osman contributes a long and interesting article on the use of alkalis in Bright's disease. Stalling's work on the physiology of excretion is described, and

Dr. Nicholson writes upon the development of the kidneys. There are many shorter articles, e.g. *Surgical Treatment in Chronic Bright's Disease*, *Syphilitic Nephritis*, *Tonsillar Sepsis and Nephritis*, *Mental Symptoms in Bright's Disease and Enuresis Nocturna*.

The Report forms an interesting collection. There is an understandable though slightly confusing diversity of opinion amongst the different authors.

EXPOSURES OF LONG BONES AND OTHER SURGICAL METHODS. By ARNOLD K. HENRY. (John Wright & Sons.) Pp. 80. Illustrations 51. Price 10s. 6d.

The methods of exposure of the long bones recommended by the author are in the main entirely original. They are based on sound anatomical principles, and require a fair knowledge of that subject for their successful application. The anatomical details are very carefully described, and each procedure is fully illustrated.

The exposure of the whole length of the shaft of the femur is accompanied by an anterior incision, the bone being reached by splitting the crureus, and drainage obtained by posterior counter-drainage openings after separating the muscles from the bone. Quite as satisfactory an exposure would, however, be obtained in the majority of cases by separating the vastus lateralis only, commencing at its medial border.

Methods of ligating the first part of the subclavian and second part of the vertebral artery are also included, but these procedures are unlikely to be required in the lifetime of the average surgeon.

An operation for the removal of the cervico-dorsal ganglion of the sympathetic for the treatment of angina pectoris is described, and a highly ingenious run for the removal of a pituitary tumour or implantation of radium into it.

The first part of the book is deserving of careful attention by any surgeon, and should be of considerable interest to the orthopaedic surgeon. The later chapters are of less immediate practical importance.

The book is well written, and the illustrations, taken from the author's articles in the *British Journal of Surgery*, are clear.

MANUAL OF SURGERY. (Rose and Carless). By ALBERT CAHNESS, C.B.E., M.B., M.S., F.R.C.S., and C. P. G. WAKELEY, F.R.C.S., F.R.S.E. Twelfth edition. (London: Baillière, Tindall & Cox, 1927.) Pp. 1544. Figs. 639. 19 plates. Price 35s. net.

The twelfth edition of this text-book has altered with the times, and can still claim the serious consideration of the student who wishes to buy a comprehensive one volume manual of surgery. The ground covered is wide, and there are few aspects of general surgery left untouched.

The illustrations, on the whole, have not that high finish which is found in other text-books of surgery, but they are reasonably clear, and, after all, one museum specimen or one patient seen is worth ten illustrations.

This edition has been brought up to date. Especially good is the radiographic supplement of seventy-eight excellent figures illustrating various conditions. The index is full and accurate.

COMMON DISEASES AND DISORDERS OF CHILDHOOD. By G. F. STILL. Fifth edition. (Humphrey Milford, Oxford University Press.) Pp. 1022. Price 30s. net.

This monumental book, which has formed the basis for all present-day paediatric writings, is very welcome in its 1927 edition. In accordance with a modern tendency brought out in such examinations as the M.B., the author has added a fresh chapter on a symptom—a useful approach to the subject—in this case vomiting. Other new chapters deal with cretinism and erythroderma.

The book first appeared, it is interesting to remember, as a collection of lectures delivered at King's College Hospital, Great Ormond Street, and was to have been called "Lectures on Diseases of Children," thus anticipating Mr. Robert Hutchison's well-known book of that name. Note taking is to many an impossible thing to start, but it is stimulating that Dr. Still attributes his vast knowledge to this "inveterate habit" of his.

The book is eminently readable, nothing is put down but what has been seen personally or proved to the author's satisfaction, and

as the root of knowledge is often better than the branch, so we consider Still's work should be read before all others dealing with children.

PRACTICAL BIRTH CONTROL. By E. A. HORN BROOK. (London: William Heinemann (Medical Books), Ltd., 1927.) Pp. 54. Price 3s. 6d.

Mrs. Hornbrook argues that, pending the formulation of any reasonable system of eugenics, the future of the race lies in the hands of intelligent woman. To the enlightenment of such the book is addressed. The description of contraceptive methods is clear and adequately illustrated, and the practical exhortations to cleanliness, if carried out, would do much to lessen the reported evils following the use of contraceptive apparatus.

Unintelligent women might not fare so well with the book. For their sake, for instance, Mrs. Hornbrook might have written her remarks upon abortion from a less detached and a more condemnatory standpoint.

HANDBOOK OF DISEASES OF THE NOSE, THROAT AND EAR. By W. S. SYME, M.D., F.R.F.P. & S.G., F.R.S.E. Second edition. (Edinburgh: E. & S. Livingstone, 1927.) Price 12s. 6d.

This is a readable and compact handbook on its subject. For students who do not wish to make a deep study of these diseases, and for the practitioner who needs a book of reference, it should be useful. X-ray photographs and some coloured illustrations have been added, amongst the matter which brings this second edition up to date. Something a little more pre-Raphaelite is to be desired in the colouring of the illustrations.

The setting out and printing of the sections is clear. The list of formulae at the end of the book is a useful feature.

AIDS TO THE DIAGNOSIS AND TREATMENT OF DISEASES OF CHILDREN. By JOHN McCRAW, M.D.(R.U.I.), L.R.C.P.(Edin.). Revised by FREDERICK M. B. ALLEN, M.D.(Bel.), M.R.C.P.(Lond.). Sixth edition. (London: Baillière, Tindall & Cox.) Pp. viii + 330. Price 5s. net.

The new edition of this work has been revised and brought up to date by the addition of new material on rickets, the specific fevers and encephalitis lethargica. The volume is full of information, very well expressed, and on the whole more detailed than the average member of the Aids series. A number of references to standard works are given when fuller information might prove desirable, all of which references are well chosen.

The chapter on artificial feeding has been modified in an attempt to simplify the subject, but the experiment has not been very successful, the resultant impression being one of compression with consequent confusion.

With this one exception the book presents a clear and concise summary of disease in children, and can with confidence be recommended to those who do not desire to read the more voluminous works on this subject.

SYNOPSIS OF PHYSIOLOGY. By A. RENDLE SHORT, F.R.C.S.&C.I. (Ham.), M.B., B.Ch. (Bristol: John Wright & Sons, Ltd.) Pp. 258 with diagrams. Price 10s. 6d. net.

This volume is a further addition to the ever-increasing number of synopses on the subject. As pointed out in the preface, it is not claimed to be a text-book, and hence its scope must necessarily be limited. However, the book will be found useful for purposes of revision and examinations.

The arrangement on the whole is good, and reference is made to the more important recent work.

The omission of the final "e" in the spelling of the amino-acids, e.g. glycine, is to be regretted, because it will certainly lead to much confusion.

In the light of Mellanby's recent work sufficient stress is not laid upon the importance of secretion in gastric and pancreatic digestion. The statement that only three vitamins have definitely been identified is far from correct, since Webster and Rosenheim have recently shown that the all-important antirachitic vitamin D can

be artificially produced by irradiation of ergosterol and considerable experimental evidence is at hand to establish the existence of the fat-soluble Vitamin E.

In dealing with the functions of the iris, one of the chief, viz. to increase depth of focus, has been overlooked.

DISEASES OF THE THROAT, NOSE AND EAR. By DAN MCKENZIE, M.D., F.R.C.S.E. Second Edition. (London: William Heinemann, Ltd., 1927.) Pp. 677. 3 Plates and 254 Figs. Price 45s. net.

This second edition of McKenzie's book retains the system of the first. The diseases are dealt with mainly from the clinical and operative standpoint, the pathology and other issues being treated incidentally. The operative surgery is stressed, and though the more rare modifications of technique are not treated, the descriptions are admirably lucid and well illustrated.

Much new material has been added since the first edition, and makes the book fairly representative of modern advances in its subject.

The price of the work and its specialized and detailed matter make it essentially one for the specialist or would-be specialist. To either we can recommend it.

POST-MORTEMS AND MORBID ANATOMY. By THEODORE SHENNAN, M.D., F.R.C.S.(Edin.). Professor of Pathology in the University of Aberdeen. Second edition. (London: Faber & Gwyer, Ltd.) Pp. 664. Price 25s.

This edition of Dr. Shennan's book is described by the author as being "practically a new book," by virtue of the additions and alterations which he has made in it.

One suspects that future editions will not be so novel, for the book should long remain in its present eminently useful form.

The first part of the book describes post-mortem technique, together with the naked-eye appearance of all the organs in their various diseased states. The accounts are true and vivid, and full of detail. They are assisted by numbers of original photographs of high quality.

The information contained, besides being concise and accurate, is complete. It could not be extended very much without embracing microscopy.

At the end of the book are some very convenient sections on the medico-legal aspect of post-mortem work, and on methods of preservation.

The book is to be very highly recommended both to students and practitioners.

AIDS TO BIOCHEMISTRY. By COOPER and NICHOLAS. (Baillière, Tindall & Cox.) Pcap 8vo. Pp. viii + 188. Price 4s. 6d.

In the preface it is stated that the work is not intended as a text-book, and is only to be used for revision; it would seem, therefore, unnecessary to give full practical details of the analytical and other experimental methods described.

A criticism of the selection of certain methods may be made. For the estimation of blood-sugar, the method of Hagedorn and Jensen is as accurate as that of Mclellan and is easier to carry out.

There are some omissions of importance; for instance, no reference is made to the volatile fatty acid contents of fats.

The desirability of including black and white sketches of osazone crystals may be questioned; no real idea of their appearance can be obtained, except by actual examination of specimens.

On the whole the book seems accurate and up-to-date. For instance, the amylenic oxide formula for glucose is given.

DIATHERMY. By ELKIN P. CUMBERBATCH. (Wm. Heinemann, Ltd.) Price 21s.

The second edition of this book contains much new and valuable matter.

There are three main sections.

The first is on physics, apparatus and experimental diathermy and is adequate.

The second part deals with diathermy in medical conditions, and should be of great interest to physicians and electrologists alike. It gives a full description of the technique and results of treatment in gonococcal infections treated by this method, and of the treatment of various types of arthritis. Many other conditions are also mentioned. Unfortunately no statistics of the critical kind demanded by modern scientific investigators are given, and there is a tendency to quote a single case in support of diathermy in the treatment of some conditions, which leaves the practitioner in some doubt as to the actual value of diathermy and its present place in therapeutics.

The third part deals with diathermy as an aid to the surgeon. Some conditions, such as papilloma of the bladder are best treated thus, but the author quotes many American exponents who use it for carcinoma of the breast instead of the ordinary knife. Here, again, there are no comparative statistics between this and other methods.

The book is the best that has as yet been written in the English language on diathermy, and no doubt in a year or two full data will be at hand, and the uncertainty as to prognosis when this treatment is to be adopted, will be to some extent allayed.

RUGGER. By W. W. WAKEFIELD and H. P. MARSHALL. (London: Longmans, Green & Co., Ltd.) Price 15s. net.

This volume forms a welcome addition to Rugby Football literature, its value being enhanced by the fact that the authors themselves are in the front rank of present-day players.

The book is divided into three sections: the first part being the reminiscences of W. W. Wakefield, the second dealing with the theory of the game, while the last part consists of international and other records. It is, however, the second section which is of most interest.

In the opinion of the authors, the fundamental principle of modern football is based upon intelligent wing-forward play; this phase of the game is considered with great thoroughness, but, unlike so many books on rugby, it is never forgotten that players are, after all, only human, and not machines. Somewhat naturally, as both Wakefield and Marshall are forwards themselves, toward play receives most attention, but back play has by no means been neglected, and stress is laid upon those little details so often forgotten by the three-quarter, but which are so necessary if the side is to play as a team, not as a crowd of individuals.

One has learned much from these chapters, not perhaps so much from what is set down in point as from the suggestions which have opened up new avenues of thought and given rise to fresh points of discussion.

In the chapter dealing with Histories of the Clubs, the Hospital is only given credit for having had three international players, the names of two who played for "Bart's" in the 'eighties having been omitted. There is, however, a full record of our post-war achievements.

There is one adverse criticism to make, and this concerns the last section of the book, which strikes one as being unnecessary. It is merely a reprint of what appears every year in the Rugby Football Annual, and in three months' time, when this season's internationals have been played, these records will be incomplete and out-of-date.

## BOOKS RECEIVED.

FROM THE LOG OF AN OLD PHYSICIAN. By X. Y. W. (London: Selwyn & Blount, 1927.) Price 2s. 6d.

A PLEA FOR A THOROUGH INVESTIGATION OF THE FILARIASIS PROBLEM. By SIR FRANK CONNOR, D.S.O., F.R.C.S. (A reprint from the *Indian Medical Gazette*, vol. LXI, May, 1927.)

HINTS TO PROBATIONER NURSES IN MENTAL HOSPITALS. By RICHARD EAGER, O.B.E., M.D. (London: H. K. Lewis & Co.) 1s. 6d.

MACALISTER LECTURE ON DIET AND DIETETICS. By SIR THOMAS HORDER, Bart., K.C.V.O., M.D., F.R.C.P.

NEOPLASM IN AN INDIAN RHINOCEROS (SARCOMA OF THE HEART AND LUNGS). By H. HAROLD SCOTT, M.D., F.R.C.P.(Lond.), F.Z.S. (From the *Proceedings of the Zoological Society of London*, 1927.)



- SPRUE IN NATIVES. By G. CARMICHAEL LOW, M.A., M.D., F.R.C.P., and D. BENTON, M.R.C.S., L.R.C.P. (Reprint from the *Journal of Tropical Medicine and Hygiene*, August 1st, 1927.)
- THE APOLOGIA OF AN ACROMEGALIC. By LEONARD FORJAL MARK, M.D. (Reprinted from the *Medical Press and Circular*, October 5th and 12th, 1927.)
- THE BIRTH OF MANKIND, OR THE WOMAN'S BOOK: A BIBLIOGRAPHICAL STUDY. By SIR D'ARCY POWER, K.B.E., F.R.C.S., P. Bibliographical Society.
- THE BROAD ROAD OF HEALTH: A REJOINDER. By SIR THOMAS HORDER, Bart., K.C.V.O., M.D., F.R.C.P.
- THE OCCURRENCE OF PARATYPHOID IN SHANGHAI. By E. P. HICKS, M.B., B.A., D.T.M.&H., and R. C. ROBERTSON, M.C., M.D., D.P.H. (Reprint from the *China Medical Journal*, September, 1927.)
- THE RELATION OF RAT-FLAS TO PLAGUE IN SHANGHAI. By E. P. HICKS, M.B., B.A., D.T.M.&H. (Reprint from the *Journal of Hygiene*, vol. xxvi, No. 2, July, 1927.)
- TWO CASES OF PERITONEAL NEOPLASM (ENDOTHELIOMA). By H. HAROLD SCOTT, M.D., F.R.C.P. (London), F.Z.S. (From the *Proceedings of the Zoological Society of London*, 1927.)

## EXAMINATIONS, ETC.

## UNIVERSITY OF OXFORD.

The following degrees have been conferred:  
B.M., Bortie, L. W. H., Gilding, H. P., Kingsley, A. P.

## UNIVERSITY OF LONDON.

*Third (M.B., B.S.) Examination for Medical Degrees, November, 1927.*  
Pass.—Cholmley, J. A., Dewhirst, D. A., Fells, R. R., Forrest, J. R., Hardwick, S. W., Harries, G. E., Holmes, J. W. O., Lewys-Lloyd, R. A. V., Mogan, W. S., Nicol, W. D., Payne, R. T., Posel, M. M., Rees, E. R.  
*Supplementary Pass List. Group I.* Hartsilver, J., Macdonald, A. R. *Group II.* Aldridge, J. S., Griffiths, T. R.

## ROYAL COLLEGE OF SURGEONS.

December, 1927.

The following were successful at the examination for the *Primary Fellowship*:  
Bell, A. C. H., Chaudhuri, A. M., Coltart, W. D., Knight, C. C., Phillips, R. F., Renham, E., Taylor, H., Watts, C. F.

The following were successful at the examination for the *Final Fellowship*:  
Biggar, B., Braddon, P. D., Broomhead, R., El Katib, A. S., Evans, D. J., Freeman, E. A., Jayasuriya, J. H. F., Milner, S. M., Moir, E. D., Robb, W. M., \*Seddon, H. J., Weddell, J. M.  
\* Not having attained the requisite age, is not yet entitled to receive the Diploma.

## CHANGES OF ADDRESS.

- BOURNE, GEORGE, 25, Harley Street, W. 1. (Tel. Langham 1895.) Flat B, 356, Gray's Inn Road, W.C. 1. (Tel. Museum 1909.)
- DAVIES, T. G., Surg. Lt., R.N., I.I.M.S. "Cumberland," c/o G.T.O., London.
- DRUTY, A. E., 8, Oakhurst Road, Highfield, Southampton.
- PAYNE, R. T., 49, Harley Street, W. 1. (Tel. Langham 2079.)
- SPICER, W. T., HOLMES, Elmley House, Wimbledon Common, S.W. 10. (Tel. Putney 0454.)
- TANNER, G. M., The Laurels, Newton Abbot, S. Devon. (Tel. 41.)
- TROWER, W. R., 4, Belvedere, Weymouth.

## APPOINTMENT.

CATFORD, E., M.R.C.S., L.R.C.P., appointed Hon. Anaesthetist to Torbay Hospital, Torquay.

## BIRTHS.

- ARTHUR.—On November 17th, 1927, at Golden Rock, Trichinopoly, S. India, to Violette, wife of G. Kilpatrick Arthur—a daughter.
- HILL.—On December 1st, 1927, at Dalestead, Caterham Valley, Surrey, to Ruth, wife of F. T. Hill, M.C., M.R.C.S., M.R.C.P.—a son.
- RUSHWORTH.—On December 12th, 1927, at Orchard Corner, Walton-on-Thames, to Mary Eleanor, wife of Arthur N. Rushworth, M.R.C.S., L.R.C.P.—a son.
- WILKINSON.—On December 2nd, 1927, at Kisumu, Kenya, to Lilian, wife of Wallace Wilkinson, M.R.C.S., L.R.C.P. (Beech House, Bulwell)—a son.

## MARRIAGES.

- CUNNINGHAM—WHYTE.—On December 31st, 1927, at Hesketh Church, by the Rev. B. T. Bowker, brother-in-law of the bridegroom, Ronald, youngest son of the Rev. T. J. Cunningham and the late Mrs. Cunningham, of Preston, to Janet, only daughter of the late James Whyte and the late Mrs. Whyte, of London.
- EMMONS—MAZZINI.—On December 5th, 1927, at St. Andrew's Church, Hauble, Robert van Buren Emmons to Anita Maddalena Mazzini, of Milan, Italy.
- TINCKER—BATES.—On December 8th, 1927, at St. Mary's Church, Mablethorpe, Suffolk, by the Rev. F. Doughty, M.A., assisted by the Rev. H. Naughton Bates, B.A. (brother of the bride), Dr. R. W. Holden Tincker, of Painswick, Gloucester, younger son of the Rev. D. C. and Mrs. Tincker, of Cleckheaton, to Kathleen Aldrich, eldest daughter of the late Rev. E. Bates, and of Mrs. Bates, of Martlesham Hall, Suffolk.

## DEATHS.

- FIELD.—On December 9th, 1927, at Falmouth, Cornwall, Albert Frederick Field, M.D., late St. Bartholomew's Hospital, aged 83.
- GRESSWELL.—On December 13th, 1927, at Mercer Row, Louth, Lincs., Albert Gresswell, M.A., M.D. (Oxon.), aged 71.
- JACKSON.—On December 5th, 1927, in Paris, Marshall Jackson, W.A.M.S., much-loved younger son of the late Surgeon-Major Warwick Jackson, I.M.S., and Mrs. Jackson, Leighou Buzzard.
- SWINTON.—On December 23rd, 1927, suddenly, of pneumonia, in Bombay, Lieutenant-Colonel Francis Edward Swinton, C.I.E., late Indian Medical Service, eldest surviving son of the late Robert Blair Swinton, Madras Civil Service, aged 60.

## ACKNOWLEDGMENTS.

*Broadway—British Journal of Venereal Diseases—The Charing Cross Hospital Gazette—Guy's Hospital Gazette—St. George's Hospital Gazette—The Hospital Gazette—The Journal of the Research Defence Society—The London Hospital Gazette—The Long Island Medical Journal—The Medical Review—The New Troy—The Nursing Times—The Post-Graduate Journal—The Queen's Medical Magazine—Reale Società Italiana D'Igiene—Revue de Médecin—Rivista di Patologia e Clinica Della Tuberculosi—The Student.*

## 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, E.C. 1.

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, MR. G. J. WILLIAMS, M.B.E., B.A., at the Hospital.

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0510.

## St. Bartholomew's Hospital



## JOURNAL.

"Æquam memento rebus in arduis  
Servare mentem."

—Horace, Book ii, Ode iii.

VOL. XXXV.—No. 5.]

FEBRUARY 1ST, 1928.

PRICE NINEPENCE.

## CALENDAR.

- Wed., Feb. 1.—Surgery. Clinical Lecture by Sir C. Gordon-Watson.
- Fri., " 3.—Dr. Langdon Brown and Mr. Harold Wilson on duty.  
Medicine. Clinical Lecture by Dr. Langdon Brown.
- Sat., " 4.—Hockey Match v. Christ Church, Oxford. Home.  
Rugby Match v. Devonport Services. Home.  
Association Match v. Old Cholmeians. Away.
- Mon., " 6.—Special Subject. Clinical Lecture by Mr. Rose.
- Tues., " 7.—Prof. Fraser and Prof. Gask on duty.
- Wed., " 8.—Surgery. Clinical Lecture by Mr. L. B. Rawling.  
Hockey Match v. Mill Hill School. Away.
- Fri., " 10.—Dr. Morley Fletcher and Sir Holburn Waring on duty.
- Sat., " 11.—Rugby Match v. Pontypool. Home.  
Hockey Match v. R.M.C. Sandhurst. Away.  
Association Match v. Emmanuel College, Cambridge. Away.
- Mon., " 13.—Special Subject. Clinical Lecture by Mr. Elmslie.
- Tues., " 14.—Sir Percival Hartley and Mr. L. B. Rawling on duty.  
Cup Tie. Rugby Match v. Winner of St. Mary's v. St. Thomas's.
- Wed., " 15.—Surgery. Clinical Lecture by Mr. L. B. Rawling.
- Fri., " 17.—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
- Sat., " 18.—Association Match v. Old Bradfieldians. Home.  
Rugby Match v. O.M.T. Away.  
Hockey Match v. Old Uppinghamians. Home.
- Mon., " 20.—Special Subject. Clinical Lecture by Mr. Elmslie.  
**Last day for receiving matter for the March issue of the Journal.**
- Tues., " 21.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
- Wed., " 22.—Surgery. Clinical Lecture by Sir C. Gordon-Watson.  
Hockey Match v. Epsom. Home.
- Thurs., " 23.—Semi-final of the Rugby Football Cup Tie.
- Fri., " 24.—Prof. Fraser and Prof. Gask on duty.  
Medicine. Clinical Lecture by Sir Percival Hartley.
- Sat., " 25.—Rugby Match v. Glamorgan Wanderers. Away.  
Association Match v. Keble College, Oxford. Home.
- Mon., " 27.—Special Subject. Clinical Lecture by Mr. Scott.
- Tues., " 28.—Dr. Morley Fletcher and Sir Holburn Waring on duty.
- Wed., " 29.—Surgery. Clinical Lecture by Mr. Harold Wilson.

## EDITORIAL.

**M**R. McADAM ECCLES has been a notable figure at the Hospital for so long that it is difficult to appreciate that he has actually left us. That he has retired at 60 is a striking example of that conscientious honesty which he carries into the smallest details of his practice, and it is a powerful argument in favour of one of his maxims—the reduction of the age-limit.

As a member of the Council of the Royal College of Surgeons and of the B.M.A. with the Chairmanship of the Hospital Committee added to the pressure of his private work, to which he is anxious to devote more time, the absence of Hospital routine will probably be very welcome to him.

At the dinner on January 10th, given to Mr. Eccles by his house surgeons, past and present, he ran over in his delightful way the main landmarks in his eventful life, and we cannot do better than mention some of these as a permanent record of so notable a career.

Two blots can be found on Mr. Eccles's otherwise scrupulously clean sheet: He did little work at school, and he nearly failed in Physics at University College. He made up for this last, however, by winning his first Gold Medal—for Chemistry.

It was, however, when he entered this Hospital in 1885 that he met with real success, winning the Harvey and the Bentley, and a Gold Medal for *Materia Medica*. He qualified in 1890 and went on to M.B., B.S., F.R.C.S., and the Gold Medal in the M.S. examination. After becoming Assistant Surgeon at the West London Hospital he won the Jacksonian Prize, became Demonstrator in Anatomy and Operative Surgery at this Hospital, and 1903, thirteen years after qualifying, became Assistant Surgeon to Mr. Bruce Clarke. Nine

years later he reached the Senior Staff; since then his Assistant Surgeons have been Mr. Etherington Smith, Mr. Harold Wilson and Mr. Girling Ball.

As an Examiner in Anatomy for the Conjoint and Fellowship and for the Cambridge and Conjoint Surgery his efforts were very far-reaching. Like all great men he has been considerably libelled in verse; the second verse of one of the best examples which we publish is:

"By faith which, according to rumour,  
Large mountains has cast into seas,  
He removes an abdominal tumour  
With simply ridiculous ease."

His long association with this JOURNAL, both as member and then Chairman of the Publication Committee, makes us want to give a prominent place to this account of his departure. We understand that this is in no sense a retirement; his work in private will continue unabated, and then in the Hospital we shall hope to see and hear him at consultations.

\* \* \*

The death of Mr. Basil Lang, an obituary of whom we publish on another page, must be noted here also as having a special meaning, in that he originated the idea of *Round the Fountain*, the fourth edition of which is now on promotion, a fact which is mentioned in the attractive notice of this edition which appeared in the *British Medical Journal* a few weeks ago.

\* \* \*

We have been asked to include the following announcement:

#### CONFERENCE ON RHEUMATIC DISEASES.

A Conference on Rheumatic Diseases is to be held at Bath on Thursday and Friday, May 10th and 11th, 1928. Sir George Newman, Chief Medical Officer of the Ministry of Health, has kindly consented to act as President of the Conference. There will be three sessions: (1) Social Aspects, presided over by Lord Dawson of Penn, (2) Causation, presided over by Sir Humphry Rolleston (Regius Professor of Physic, Cambridge), and (3) Treatment, presided over by Sir E. Farquhar Buzzard (Regius Professor of Medicine, Oxford). The local Hon. Medical Secretary is Dr. Vincent Coates, 10, Circus, Bath.

\* \* \*

We congratulate Sir Thomas Horder on being given the Freedom of Shaftesbury, which has only one other Freeman on the roll.

**The Warden requests us to state that the closing date for applications for House Appointments in May is 12 noon, Saturday, February 18th, 1928.**

\* \* \*

The Hunterian Oration will be delivered on Tuesday, February 14th, by Sir H. J. Waring, M.S., F.R.C.S., and the Arris and Gale Lecture on the preceding day by Adolphe Abrahams, M.D., M.R.C.P., on "The Physiology of Violent Exercise in Relation to the Possibility of Strain."

\* \* \*

Prof. Sir Humphry D. Rolleston, M.D., has been appointed to represent the University of Cambridge at the celebration on May 14th-18th, 1928, by the Royal College of Physicians, of the tricentenary of the publication of William Harvey's book, *De Motu Cordis*.

\* \* \*

Lord Dawson of Penn gave the Abernethian Society an extremely interesting address last week on "Those other Practitioners." His well-balanced phrases, commented on by Dr. Geoffrey Evans, who proposed the vote of thanks, are well worth publishing, and will appear in our next issue.

## OBITUARIES.

### SIR DYCE DUCKWORTH.

**W**E regret to announce the death of Sir Dyce Duckworth on Friday, January 20th, at his residence in Grosvenor Place at the age of 87. The following is taken from the *Times*:

Sir Dyce Duckworth was born on November 24th, 1840, the youngest son of Robinson Duckworth, of Huddersfield, and Elizabeth Forbes, daughter of Dr. Nicol, of Stonehaven, N.B. He was educated at the Royal Institution School, Liverpool, and afterwards at the University of Edinburgh. In 1861 he came to London with an introduction to Sir James Paget, and in the following year he returned and served as a clinical clerk at St. Bartholomew's Hospital under Sir George Burrows. In 1863 he graduated M.D. at Edinburgh with honours and the gold medal, and was appointed

Resident Physician to the Clinical Wards at the Royal Infirmary.

He entered the Royal Navy as an assistant surgeon in 1864, but never served afloat, for while he was at Plymouth, Dr. Kirkes, Medical Tutor to St. Bartholomew's Hospital, died, and Duckworth was appointed to succeed him in this important post. He settled in London and shortly afterwards was appointed Physician to the Royal General Dispensary, where he had Sir William Selby Church as his colleague. In 1867 Church and Duckworth were elected Assistant Physicians at St. Bartholomew's. In due course Duckworth became full Physician, holding the office for 22 years, until he resigned in 1905 on attaining the age-limit of 65, and was immediately appointed Consulting Physician to the Hospital.

The high estimation in which Duckworth was held by his fellow Physicians was shown by his appointment as Treasurer of the Royal College of Physicians as early as 1884, and this post he retained until 1923, when he was appointed Emeritus Treasurer. Indeed, at the Royal College of Physicians, Duckworth filled every honourable position to which he could be appointed except that of President. He was the representative on the General Medical Council from 1886 to 1891, representative governor at the University of Liverpool, Senior Censor, Harveian Orator, and an examiner in medicine, while as a member of the Board of Management of the Conjoint Examining Bodies of the Royal Colleges of Physicians and Surgeons he did much to improve medical education in this country. From 1890 until 1901 he was Honorary Physician to King Edward VII when Prince of Wales. In 1886 he received the honour of knighthood, and in 1909 he was created a baronet.

Duckworth devoted his attention more especially to gout and rheumatic affections of the joints. He practised with much success at 11, Grafton Street, Piccadilly. He was a good example in modern times of the old courtly physician, somewhat formal in manner, soft-spoken, rather slow, but easily kindled to wrath, for he did not suffer fools gladly. He was transparently honest, an excellent teacher, and a sound consultant. Honours came to him unsought from many quarters. He was President of the Clinical Society of London from 1891 to 1893, and was medical referee to the Treasury and to the Pensions Commutation Board from 1904 to 1910. He attached himself early to the Order of St. John of Jerusalem, of which he was a Knight of Justice and an Almoner, and he took an active part in the work of the medical Guild of St. Luke. He was for some years Chairman of the Royal British Nurses' Association, and throughout his life he was a champion of the nursing profession.

Sir Dyce Duckworth was twice married. By his first wife he leaves an only son, who succeeds to the title, Mr. Edward Dyce Duckworth, formerly a judge of the High Court at Rangoon.

### MR. BASIL LANG.

Many of us will feel that we have sustained a personal loss in the death of B. T. Lang.

His was a very prominent personality, so that since he first came to the Hospital from Cambridge in 1902 he has been well known by successive generations of Bart's men. Perhaps his outstanding characteristics were his great good nature and his versatile ingenuity. It gave him real pleasure if he could assist anyone in any way, and those who knew him best will be aware to what trouble and pains, and often to what expense, he would go, in helping those to whom he felt he could be of assistance.

His special bent was things mechanical, and in this direction he showed extraordinary ingenuity, which almost amounted to genius. Anything in the way of a gadget gave him the greatest possible joy. He would grasp its working instinctively, and immediately proceed to dissect it to see in what way it could be improved.

I remember on one occasion when he was in the "House" going into his room and finding him with his coat off, in a sulphurous atmosphere, practising revolver shooting, the target being an out-of-date *Medical Directory*. The real joy of the game was the fact that it was a new revolver which came to pieces, as he explained, in two movements, and in almost a few seconds.

The war provided opportunities for his adventurous spirit, and he was very soon to be found in France in charge of the first travelling X-ray equipment. As the war wore on he filled many positions, and on one occasion he told me that up to date he had lived in thirty-two different messes. In due course he was appointed to an ophthalmic post, and afterwards did none but eye work. This, however, did not mean that his energies were at last to be harnessed, for sometimes, to the chagrin of his colleagues, who were left to carry on, he would disappear in the middle of the morning, not on account of any bodily indisposition, but in order (as it afterwards turned out) to fix some rubber soles on to one of the Sisters' shoes, or to mend the "Flamme bleu" stove. On a winter's morning one of the radiators in the Theatre had burst from frost, and he usurped the post of plumber with results that were astonishing, and which were not limited to his personal appearance. During this time

he invented a range-finder for anti-aircraft, which was adopted by the War Office.

Whilst in France he developed some form of myocarditis, for which he was temporarily invalided home, and from which it is doubtful whether he recovered completely; and it seems more than likely, from what Dr. Canti has told me, that this was an important factor in the fatal termination of his pneumonia.

After the war he settled down to serious ophthalmic practice, was appointed to the staff of Moorfields, and soon firmly established himself. He set himself to perfect a perimeter and spent much time and energy and money on it. It was a very great improvement on anything which had gone before.

The circle of friends who deplore his premature death will, I fancy, be much wider than he would have guessed.

### ST. BARTHOLOMEW'S HOSPITAL GOLFING SOCIETY.

**A**t the Annual Staff and Students' Golf Match on May 18th, 1927, the St. Bartholomew's Hospital Golfing Society was formed. Sir Charles Gordon-Watson was elected President, and G. Graham and R. S. Corbett Secretaries. H. Carson, C. M. Hinds Howell, C. H. J. Iott, T. H. Just and C. E. Woodrow were elected to serve on the committee.

All past and present students who are on the Medical Register are eligible for membership. The entrance fee will be five shillings, and a subscription of half a crown will be paid by all those who play in the summer competition.

The first meeting will be held on Wednesday, June 20th.

Sir Charles Gordon-Watson has given a Challenge Cup for the best bogey score under handicap. A four-some competition against bogey will be held on the same day, and supper will be arranged after the meeting if possible. It is hoped that all who play golf will join the Society, and send in their names and entrance fees to one of the Secretaries, c/o St. Bartholomew's Hospital.

### INTRA-CRANIAL AEROCELE: COLLECTED CASES.

**E**XCLUDING air introduced by the surgeon for diagnostic purposes, air within the cranium is usually the result of trauma, especially that which causes fracture of the anterior fossa of the skull. Intra-cranial aerocele is not common. The cases here collected have been found with some difficulty and no doubt other similar cases are on record. Cases of intra-cranial gas formation by bacteria are excluded from this article. Cushing records four cases of orbito-ethmoidal osteomata, two of which showed an intra-cranial aerocele and are detailed here as illustrative cases.

**CASE 2 (Cushing).** "Orbito-ethmoidal osteoma, with intra-cranial complications. Convulsions and recurrent orbital infections. Previous lateral craniotomy with drainage of aerocele (? infected). Attempted exposure of tumour blocked by infected frontal sinus. Subsequent surgical procrastination. Nasal rhinorrhœa with ventricular pneumatocele. Death from meningitis four years after onset of symptoms.

*Ten years previously*, injury to mid-frontal region.

*September, 1920.*—Pain and swelling in right orbit. Ethmoid cells opened; *nil* found.

*April, 1923.*—Trephined; frontal lobe punctured. "An accumulation of air and cloudy serum was encountered and evacuated," also "a bony growth, as big as the end of the thumb, inside the skull near the mid-line above the nose." Temporary improvement. Cushing deferred radical operation, because of fatal result of operation in a previous case of orbital osteoma.

*October 28th, 1924.*—"Right frontal osteoplastic craniotomy. Accidental opening of infected frontal sinus. Radical operation abandoned. Drainage of sinus."

*January, 1925.*—Rhinorrhœa said to have been present intermittently for the last two years. "On lowering his head he hears (and one can hear with the stethoscope placed anywhere over the head) from three to four sharp metallic sounds, like drops of mercury striking the bottom of a tin pan. On raising and throwing back his head, he hears these three or four sounds repeated. The impression is gained that there must be, somewhere in the skull, an hour-glass-shaped pocket containing fluid with bubbles of air, which pass from one cavity to the other through a narrow neck."

"A series of X-ray films were immediately taken, which showed that the bubble of air was in the cerebral ventricle, and shifted from the frontal to the occipital ventricular horn on change of position."

*End result.*—Three months later went to bed feeling in perfect health. At 5 a.m. woke with a headache, followed by vomiting. At 10.30 a.m. had a convulsion, and died a few hours later, with a temperature of 106° F.

**CASE 3 (Cushing).**—"Huge intra-cranial pneumatocele of unexplained origin exposed and emptied at operation. Recurrence of pneumatocele. Second operation, revealing a minute pneumatic sinus alongside an orbito-ethmoidal osteoma. Closure by fascial stamp. Recovery."

*Five years previously.*—Frontal scalp wound; no suggestion of bone injury.

*One year previously.*—Headaches, with weakness of right hand, speech, memory, etc.

*October 6th, 1925.* X ray showed running backwards along frontal bone a clear area, 13 cm. long by 5 cm. wide. Also a dense shadow in region of left frontal sinus (? osteoma). No rhinorrhœa, no succussion, no evidence of fluid in cyst.

*November 12th, 1925.*—Large left osteoplastic flap. Brain over cyst bulging, rather avascular and yellowish, sharply differentiated from adjacent normal brain. The appearances were those of a gliomatous cyst covered by a thin layer of cortex. The cyst was punctured and air escaped, leaving an enormous cavity. Inspection of cavity showed no fluid and therefore no connection with the ventricle. The walls of the cyst were composed of naked white nerve-tissue, with no sign of a lining membrane. The cyst cavity was pear-shaped, and ran down to a narrow neck as shown in the skiagram. The cyst was filled with Ringer's solution, the dura was sutured, the bone flap was replaced and the wound was closed without drainage. Excellent recovery. Skiagrams taken four, twelve and nineteen days after operation showed no air in the cyst.

*January 6th, 1926.*—Eight weeks after operation; skiagram showed the cyst to contain air and fluid (Ringer's solution).

*Seventeen weeks after operation* the cyst contained more air and was larger.

*Second operation, March 25th, 1926* (eighteen weeks after first operation). "Re-elevation of former flap. Extra-dural exposure of orbito-ethmoidal osteoma projecting through dura. Removal of intra-cranial projection of tumour. Disclosure of minute canal connecting ethmoid cells with the adherent lepto-meninges, whereby the pneumatocele could be inflated. Fascial implantation. Recovery"

The connection of the cyst with the nose was proved by compressing the nose during respiration, when a bubble of air emerged from the minute channel. A piece of

fascia, 3 by 2 cm., from the patient's leg was placed between the base of the frontal lobe and the opening of the narrow channel. The bone-flap was replaced, leaving an extra-dural cavity, filled with air, between the collapsed frontal lobe and the bone. The head symptoms disappeared at once and recovery was sound.

Skiagram ten days after operation showed small amount of air still present. Skiagram twenty days after operation showed absorption of air to be complete.

Cushing refers to a collection of 50 cases of traumatic intra-cranial aerocele, in one of which the aerocele had opened into a lateral ventricle. He advocates operation from above, by large osteoplastic frontal flap, as the only route by which the orbito-ethmoidal osteoma and the track between the nose and brain can be dealt with effectively.

*Traumatic subdural pneumatocele, with air in both lateral ventricles; recovery.*—N. W. Green.—In a patient who had received a blow on the head, a skiagram showed air in both lateral ventricles, most in the left, with a large subdural pneumatocele.

*Four weeks after injury.* The frontal bone was trephined, and the subdural pneumatocele aspirated. Saline solution, injected into the pneumatocele, escaped into the naso-pharynx. For four weeks after operation there was rhinorrhœa; eight weeks after injury, succussion was noted in the head.

Skiagram two and a half months after injury (*i. e.* six weeks after operation) showed that all the air had been absorbed.

*Sixteen weeks after injury* the patient was well.

In the discussion on Green's case, Elsberg recalled a similar case seen one year previously. There was air both in the cranial cavity and in the ventricle. Except some local swelling, there were no symptoms after the injury.

*Traumatic intra-cranial aerocele; immediate operation; cerebro-spinal meningitis; death on eighth day.*—Recorded by Sir William Wheeler.—The patient fell on his right forehead, sustaining a small wound. He was conscious, but mentally confused. Blood-stained cerebro-spinal fluid trickled from his nose. On opening the skull over the right frontal lobe "air bubbled out in small quantities, followed by blood-stained cerebro-spinal fluid."

*Autopsy.*—The fracture extended through the right side of the ethmoid and involved the sphenoid. A probe, passed through the fracture, emerged from the anterior nares.

Wheeler quotes Grant (of Philadelphia) on "Traumatic Intra-cranial Aerocele" as follows: Grant collected 10 recently recorded cases, and finds that compound fracture of the skull, involving nasal sinuses, is

the commonest cause of the condition, but any compound fracture, with a dural tear, whether the nasal sinuses are involved, or not may be followed by intra-cranial aerocele. The air is always intra-dural. "The literature on the subject suggests that, owing to the danger of infection in these cases, the presence of aerocele, immediately following injury, is an indication for operation, and Grant thinks that an attempt should be made to close the dural tear. If five or six days have elapsed, and the aerocele is discovered in a photograph by accident, the sinus may have spontaneously closed, and the policy of watchful waiting for absorption should be instituted." In 6 of the cases the aerocele developed insidiously, and was found by X-rays at intervals varying from a few days to several months after injury; in some cases the injury was comparatively trivial."

In 4 cases no operation was performed. Of these, 2 recovered and 2 died—one six months after injury. Of the 6 cases operated upon, 2 recovered and 4 died; "in one a cyst containing air the size of a hen's egg was found and three succumbed to meningitis."

#### COMMENTS.

(a) Fractures of the anterior cranial fossa are not uncommon, may be caused by small degrees of violence and may be unsuspected. Of cases which survive the immediate results of the fracture, the majority remain permanently free from intra-cranial complications. A small minority develop, at intervals of a few weeks to five years or more after the injury, (1) rhinorrhœa (escape of cerebro-spinal fluid), (2) intra-cranial aerocele, (3) orbito-ethmoidal osteoma (possibly excess of callus at the site of the fracture). Cushing records 4 cases of osteoma, 2 of which had complications (1) and (2).

(b) The factors which result in a sinus, connecting the lateral ventricle, etc., with the cavity of the nose, are not fully understood. Cushing believes in the formation of an aerocele, which later ruptures into the ventricle. Cases of spontaneous cerebro-spinal rhinorrhœa are said to occur, but, with bones so thin as those of the anterior cranial fossa, pre-existing bone disease, polypi, etc., especially if treated by operation, could easily explain a small perforation of the bone. That cerebro-spinal fluid should suddenly begin to escape through bone which has never been the subject of injury or disease is highly improbable.

(c) The intra-cranial air may be (1) subdural, (2) in the substance of the brain, (3) in the lateral ventricle, where the mixture of air and fluid may cause the sign of succussion, or (4) in a combination of any of these sites.

(d) Intra-cranial air, *per se*, is not dangerous, being absorbed in a few weeks. The danger to life lies in the possibility of intra-cranial sepsis, which may occur years after the original injury. So long as there is an escape of cerebro-spinal fluid, or a repeated re-entry of air into the skull (shown by failure of the aerocele to disappear by absorption), the risk of meningitis remains. Both the air and the infecting bacteria usually enter from the nose through a persisting opening in the fractured anterior fossa. A point in the treatment of cases known to have a communication between the cavity of the nose and the intra-cranial contents is to prohibit all nose-blowing, and, as far as possible, to avoid sneezing and coughing, or anything which tends to raise the pressure of the intra-nasal air.

(e) *Treatment*.—An aerocele, discovered during the first few days after injury, unless there are other indications for operation, is probably best left alone. When, after many weeks, either the cerebro-spinal rhinorrhœa or the aerocele is still present, the question of operation has to be considered. Grant and Cushing are agreed that, in these late cases, the indication is to close or shut off the opening leading from the nose to the brain. In 2 cases Cushing has done this and saved the patients. A very large osteoplastic frontal flap is made and the floor of the anterior fossa exposed by elevating the frontal lobes. If an osteoma is present, it is either partly or wholly removed. The opening into the nose is demonstrated and closed by laying over it a piece of fascia, about 1 in. square, taken from the patient's leg. The fascia lies between the bone and the frontal lobe. Cushing is certain that the only effective approach is through the skull by a large osteoplastic flap. The operation may be very difficult, and should be undertaken only by an expert in cranial surgery.

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C. HAMILTON WHITEFORD.

## ALCOHOLISM.

**A**LF habit of taking alcohol to excess can most easily be looked upon as the symptom of some form of mental illness. It is only when the habit has been established for a number of years that it comes to be a disease in itself. Alcoholism, in either stage, must be considered as a definite illness.

There is a tendency to look upon unrestrained excess in alcohol as something for which the patient should be held to blame, and from this attitude arises that tendency to social ostracism of the patient which makes the condition in its later stage more difficult to cure.

To understand the originating cause of such a symptom as alcoholism it is necessary to consider some of the causes which are liable to give rise to mental ill-health.

For the civilized man life is a constant strain between two contending forces. On the one hand, his primitive wishes are trying to gain expression, and on the other hand, are his social ideals, which hold these in check.

Of his primitive wishes, only three need be considered: these are the instinct of self-preservation, the instinct of reproduction and the instinct to protect his own property.

The activities that arise when these instincts are aroused are checked by the training towards a state of civilization which occurred in the early days of the man's education. The result of this training is to check the expression of the instinct at some level of the mind below consciousness, so that in the completely civilized adult there is a complete unawareness that the instinct has been stimulated at all, and, although perhaps no one ever attains to this perfection of civilization, yet a large degree of this control is necessary in order that the individual may live with his fellow men.

These instincts are aroused in many different ways. They are stimulated constantly in a small degree by the ordinary conditions of life. It is not suggested that the stimulus is sufficient in such cases to arouse the emotions associated with these three instincts in their full degree. Terror, sex and rage are seldom aroused in civilized circumstances, but a smaller stimulus than would produce these extreme emotions, if it is occurring frequently, will produce quite sufficient disturbance of the mind to lead to the need for some response to the stimulus and for some activity, which is probably being denied by the social ideals to which the individual has attained.

These activities must find their outlet in some other direction, or, failing this, some means must be adopted to prevent the irritation to the motor cortex to which this stimulus gives rise.

When a man consults his doctor for this condition the restlessness is easily controlled by some drug, such as potassium bromide, but when the patient takes the matter into his own hands he may find relief in the narcotic effect which a certain dose of alcohol produces. Putting this in ordinary lay parlance, it means that a man takes alcohol to drown his troubles.

It would be of advantage to study for the moment the mechanism that is set in motion when one or other of the instincts is stimulated. They are stimulated by different means in the case of each instinct, but the result of the stimulation in the case of all three of the big emotive forces is very similar.

The instinct of self-preservation is aroused by anything sudden, anything unexpected, and anything that is not understood. The instinct of reproduction is aroused by the presence of a possible mate, and the instinct to protect our own property is aroused by the presence of anyone who threatens any of our possessions, so that it includes the maternal instinct and such social aims as the wish to preserve unharmed an ideal or a political opinion.

The result of the presence of any of these stimuli is to produce motor activity as one of its manifestations, because primitively and in lower forms of life than man, all these instincts are followed by a physical response. The self-preservation instinct is followed by running or whatever the method of escape may be, the reproduction instinct is followed by a pursuit or a display, and, possibly, by a physical contest to overcome the reluctance of a mate; and the instinct of protection would naturally be followed by a fight.

It should be observed that the conscious mind does not originate this activity, because it takes its origin in the mid-brain, and reaches the motor cortex secondarily, so producing a stimulation of the motor activity, without the intervention of any conscious effort. This can be demonstrated in many different ways and its truth must be accepted, a description of the methods of proof being outside the scope of this article.

The only part played in the mechanism by the conscious mind is that of controlling the outward manifestations of the physical activity that is being aroused. That is to say, that although a soldier in the trenches would have his self-preservation instinct stimulated by the bursting of a shell and he would be prepared for running away, yet he is prevented from taking that action by the conscious control which he has gained as a result of education, the teaching of discipline, and, possibly, by the knowledge that he would be shot if he responded automatically to the preparation for escape that has occurred in his body.

Some use must be found for the energy if the subject

of the stimulus is to remain peaceful and healthy. The same rule applies to the activity that is aroused when either of the other instincts are stimulated, and one of the greatest difficulties with which civilized man has to contend is the problem of how to utilize the motor activities aroused when the primitive instincts are stimulated.

When this occurs at long intervals, recovery can be found through the natural energies of everyday life. These utilize and employ the activities, and, in fact, it can be said that all the energies which we display in our everyday lives have this source and origin.

When, however, this stimulus is frequent or continuous, even if the degree of activity is not very great on every occasion, so long as it produces in its sum more energy than can be used in everyday life, then that energy will be a burden which the whole mental and physical system supports with difficulty. It is this factor which gives rise to so many of the symptoms that are usually recognized as "nervous" and produce the anxiety and emotional states for which these patients seek advice.

Up to this point these stimuli and the conditions to which they give rise have been dealt with as being simple, straightforward and direct, but as a rule these stimuli are much more subtle in their effect and their origin is much less easily recognized. This part of the subject can now be profitably considered.

Civilization is the result of training. As individuals we are civilized with difficulty, and our opposition to the civilizing influences is due to the fact that these influences offer an opposition to the natural expression of our primitive wishes.

To the primitive man the formation of a herd or tribe, of which he became a member, was necessary so that he might enjoy the protection which life in a community affords. A number of people living together are better able to defend themselves against enemies, and, by joining together, they can provide themselves more easily with food.

It is, therefore, under the influence of the self-preservation instinct that civilization arises, but the life of the community necessitated at once the control of the other instincts of reproduction and the protection of property. As civilization and the community life became more extensive and complex, the necessity for controlling the expression of the primitive impulses became more pronounced, until a social ideal was developed which was in complete opposition to any expression of the primitive desires.

The prenatal development of man goes through those stages which demonstrate his origin from more primitive types, and at birth he is mentally in the state of a

primitive savage. The civilizing process begins at once, and he is taught to observe all the social rules which will enable him to live in comfort in the class of life for which he is destined.

The effect of this can best be observed by taking a simple example. Let us say that the child is taught the rights of individual property, and that he is taught not to steal. He becomes aware that the attitude of everyone around him is inimical to the expression of the wish to take anything that does not belong to him. If he should break this rule later in his life, he feels afraid, he is uneasy with a feeling of guilt, and he becomes aware of what is known as the "force of conscience."

This is a change in his physical state, and is probably the reappearance of the emotional state belonging to some occasion in childhood when he was detected in the commission of some minor theft. The emotion he feels is fear, and would be exactly the same emotion as he felt when his childish theft was discovered, and when he realized that he was to be punished for the fault. There may be, and probably are, a number of these memories in the experience of everyone. Although he does not actually call to mind the experience, yet he does go through the emotion that belongs to it.

If he has been properly brought up, then these emotional states will be sufficient to prevent him from repeating the theft, and, in the end, would have their effect before the thought of stealing reached consciousness—in other words, he has become an honest man. He would be incapable of cheating at cards, and if he travelled on a railway first class with a third-class ticket he would feel uneasy until he had paid the excess fare. Such a degree of honesty could only be attained by his having gone through some extremely painful experience associated with theft at an early age.

Again, there is the example of a man whose father insisted upon the whole family speaking the exact truth. This man, when he was a boy, was detected by his father in an untruth, and he was compelled to wear for a fortnight a placard on which was written, "I am a liar." The effect of this brutal punishment in after life was to make him excessively truthful, even to the extent of telling their faults to people he knew very little. This was a constant source of distress to him, because when he restrained the impulse he felt a definite physical uneasiness.

This case illustrates the effect of early experiences and training. The same rules will apply to the effects of education in other matters, and if a man is compelled by the circumstances of his life to transgress against some such early training, the effect will be to produce a physical uneasiness or emotion, which, it should be

observed, is in the greatest number of cases the emotion of fear.

As was suggested earlier in this paper, such a continuous excitement of the motor energies of the body will result in the need for either some other expression of the energy, or for some drug which will keep the motor system quiet enough to enable the individual to live comfortably. The taking of alcohol is one such means of achieving this end, as the following case will show:

CASE 1.—Mr. E. O., æt. 37, one of a family of four boys and two girls, with both father and mother living and healthy. He had no serious illness and was good at games. At seventeen he went into a city office, and soon afterwards began to take more alcohol than he should have done.

His history showed that he was always on good terms with each member of his family. His father was reserved and undemonstrative, and his mother was a woman who left the bringing up of the children to nurses and never encouraged any of them to show her affection. It became a family tradition, of which they were rather proud, that they never showed any emotion about one another. The patient had often wished to show affection to his mother, but he had never allowed himself to do so because of the knowledge that it would be accepted coldly and that he would be repelled. There grew up in his mind the idea that it was wrong to show affection and the impulse was always checked by a feeling of guilt.

The patient married when he was 26 a very attractive girl whose appeal to him was rather physical than mental. The whole of his married life he felt compelled to control his natural affection, and it was only allowed to display itself naturally when he was half-intoxicated. His mental conflict that was thus produced increased his drinking and was a very great handicap in their lives. By the use of alcohol he was able to overcome his restraint and reach a more natural attitude. This produced a feeling of self-blame, and night after night he was in the habit of drinking to excess and going home in a state of helpless intoxication.

CASE 2.—A man, æt. 32, an artillery officer, was cashiered and degraded during the war for drunkenness. He had been previously in the Regular Army and, while in India with his regiment, at the age of 21, he had fallen in love with his colonel's wife, who had been gratified by his attention, but had never given him any affection in return. It had been his practice after visiting her to go to the mess and to take alcohol until his excitement was overcome by the effects of the drug. He was obliged to leave his regiment, and obtained a transfer into an Indian regiment, but he had by this

time found in alcohol a means whereby he could avoid facing any difficulty, with the result that eventually he was obliged to leave the Service altogether. He rejoined during the war, only to be, as stated above, cashiered for drunkenness.

These cases illustrate the way in which alcohol is used by the patient to overcome the feeling of wrongdoing, or to keep in check the disturbances that arise in the motor mechanism of the body when some emotion is being constantly aroused. It was well known that during the war the taking of alcohol saved many a man from breaking down in the trenches, enabling him to retain his courage, and controlling the activity which was aroused by his subconscious wish to run away from the danger. The greatest number of these men ceased to take alcohol when the strain was over, but it had this danger: it taught them that alcohol was a means of avoiding difficulty, and when they were subjected to other strains of a similar nature after the war, the most natural action was to have recourse to the use of alcohol again.

It is not necessary to describe the effect of a prolonged use of alcohol. It lowers the capacity for standing up to mental strain by offering a ready means of escape, and it renders its addicts less effective and less capable for that reason alone. The mental degeneration that occurs in such cases is partly the result of this use of alcohol. Apart from this the distress which is caused to the alcoholic by the knowledge that he is behaving foolishly, living inadequately and distressing and disappointing those who are fond of him is very great, and this, in its turn, leads to the taking of alcohol and the formation of a vicious circle. Later in the course of the illness comes the effect on the whole of the body of the poison of alcohol, causing degeneration of the nervous system, of the digestive tract, and of the whole body generally. These effects are well known, and are only of interest in this paper from the point of view of prognosis, the recoverability of the patient being dependent on the degree to which the body of the patient has degenerated from the poisonous effects of the drink.

Treatment.—The treatment of alcoholism offers as a rule no greater difficulty than is to be found in the treatment of other mental diseases, and it should be approached in the same way. There is a tendency on the part of those surrounding the patient to hold him blameworthy for the condition in which he finds himself. It should be the object of the physician to combat this idea, and to make the patient realize that he is suffering from an illness which can be cured. It will be found that instead of producing in the patient's mind the idea that he might as well go on drinking

because he cannot help it, it does in fact assist him to take a new attitude towards his life, and gives him the hope that he may indeed be able to recover, and live his life in the same way as those who have been ready to blame him in the past. Alcohol must be forbidden, and any slight relapse on the part of the patient must be discussed with him sympathetically and understandingly. Such a relapse may give a clue to the cause underlying the condition.

ERNEST SNOWDEN.

(To be concluded)

### A CASE OF ACUTE PANCREATITIS.

**A**CUTE pancreatitis is a comparatively rare disease, the average number of cases admitted to this Hospital being probably not more than two during the year. It belongs to the category of the "acute abdomen," and, like a perforated viscus, is manifested by the sudden onset of pain.

The ordinary text-book of surgery is not very illuminating on the question of diagnosis, but the condition has been very lucidly described by Sir Holburt Waring in conjunction with Mr. H. E. Griffiths, who have reviewed a series of fifteen cases in vol. xi of the *British Journal of Surgery*.

From the series they deduce certain typical signs and symptoms which may be present in cases of acute pancreatitis. These are as follows:

- (1) Acute sudden epigastric pain.
- (2) Vomiting.
- (3) Lax abdominal wall in contra-distinction to rigidity.
- (4) Temperature at first subnormal, rising to 101°-102° F. Pulse at first rapid and weak.
- (5) Cyanosis and jaundice.
- (6) Localized abdominal swelling.
- (7) Raised diastase content of urine.
- (8) Positive mydriatic test (Loewi's test).
- (9) Glycosuria.

Zackary Cope especially emphasizes the absence of rigidity as being a characteristic feature of the disease, as rigidity was at one time thought to be the rule. It is interesting to note that out of Sir H. J. Waring's and H. E. Griffiths's series, 13 had a lax abdominal wall.

The average age of the patient is about 50 years, while males suffer as commonly as females.

The case about to be described is atypical in many respects, although it is agreed that the signs and symptoms of this disease are very variable.

Mrs. Elsie K—, *et. 27*, a domestic servant, was

admitted to Harley Ward on the evening of November 7th, 1927, complaining of abdominal pain. She gave the following history: She had been ill for five days. On November 1st she had been out in the evening in the rain and had got wet, but did not trouble to change her clothes on returning home. She sat in front of the fire, and later went to bed feeling "creepy." Next morning she was quite well and made herself a cup of strong tea. Following this she felt faint, and half an hour later was seized with abdominal pain. The pain was severe and numbing in character, situated in the epigastrium.

She lay down for a while, which brought relief, but on rising she still felt dizzy, but not sick. This gradually passed off, and in the evening (November 2nd) consulted her panel doctor. She slept well that night.

While carrying out her domestic duties next day she again felt suddenly dizzy, with the sensation that "all her inside had dropped forward as well," which was unassociated with pain. The dizziness continued for a while on attempting to move about. The attacks of giddiness continued all that day, very little food having been taken since the first onset.

Next morning (November 4th) suffered with intermittent pain in the left side of the abdomen—"sharp, like a knife." Pain relieved by medicine prescribed by her doctor. No marked change till November 6th, when at 2-3 a.m. she was awakened from her sleep by severe pain in the lower half of the abdomen. She felt faint, and believed that she actually fainted for a period. During the ensuing hour she vomited several times, and she passed a sleepless night, while the pain was continuous up to her admission. Vomiting did not persist, but was replaced by flatulence. No further giddiness or epigastric pain.

At no time was there any pain in the back or shoulders; no pain or difficulty in micturition; no jaundice observed. Previous to admission the bowels had been confined for three days. The menses were quite natural and regular.

The patient presented the following features on examination: Pulse, 110; temperature, 97.6° F.; respirations, 28. She looked very ill, pale, but not jaundiced or cyanotic; complaining of great thirst; tongue was slightly furred, but not dry. Heart and lungs were normal. The abdomen was distended, tympanic and everywhere tender, excepting the flanks, where there was shifting dullness. The abdomen felt curiously "doughy." No loss of liver dullness; no visible peristalsis. *Per rectum*: The rectum was ballooned; no faeces; not tender. *Per vaginam* there was a doubtful resistance in the right fornix. Reflexes normal. A specimen of urine could not be obtained.

Immediate operation was decided upon, the diagnosis of general peritonitis secondary to appendicitis or salpingitis being made.

Exploratory laparotomy was performed by Mr. Alex. E. Roche. The abdomen was opened through a right paramedian subumbilical incision, revealing the peritoneal cavity distended with clear, blood-stained fluid. There was no gas, pus, clots, flakes of lymph or food. Examination of the lower abdomen revealed normal appendix and pelvic organs, while the bowels were not distended. The great omentum, however, was studded with minute yellowish-white nodules, the size of millet-seed. Two of these were removed for examination.

On palpation of the upper abdomen adhesions were felt in the region of the spleen, the liver and kidneys being normal. The pancreas was not felt to be enlarged in the mid-line. No sign of perforation could be seen in stomach or duodenum, but in the region of the pyloric end of the stomach, lying apparently below it, was an area measuring about 2 in. by 2 in., bulging forward. This was yellow in colour and of a trabeculated, gelatinous consistency.

At this stage the patient became almost pulseless; accordingly a tube was passed down to the pelvis and the abdomen closed with all haste.

The patient rallied from the operation and has progressed smoothly towards recovery. The temperature rose for five days following the operation, reaching 102° F., and then gradually settled down. The tube was removed on the second day, drainage seeming to be completed.

The following tests were carried out subsequent to operation:

The urine during the whole period of her stay in hospital was free from sugar, the diastase content being 33.3 units on two occasions. Stools were normal in appearance and did not appear fatty.

Loewi's mydriatic test negative. The peritoneal fluid contained large numbers of leucocytes and red blood-corpuscles; cultures were sterile after three days. The diastase content of the fluid was over 100 units. Sections of the nodules removed from the great omentum had the microscopic appearance characteristic of fat necrosis.

The convalescence was uneventful, and the patient left hospital one month after operation.

Thus it will be noticed that this case conformed to type only to the extent of the abdominal pain, soft abdomen and fat necrosis, while the other signs were conspicuously absent.

I am indebted to Mr. Rawling for his kind permission to report the notes of this case.

C. B. V. TAIT.

### THE PINK PAPER: A REVERIE.

**R**EACHED the Hall a trifle late, the numbers they were done;

The candidates were coming out, in groups, and one by one.

And so with mingled feelings there I waited in the gloom,  
To hear the news of my success, or maybe hear my doom.

At last I found a damsel tall, she traced my name with ease,

But when I saw her visage fall, I trembled at the knees.  
"Alas!" she said, and sadly smiled, "your name in blackest ink

Is carefully inscribed upon this flaming page of pink."

I took it very gingerly and kissed her finger tips,  
Although I should have much preferred to taste her ruby lips.

I took me sadly homewards where I dreamed of oceans wide,

With little fairy mermaids crowding round on every side.

The sky was pink, the sea was pink, the shells and seaweed too

Were delicately tinted with this same abhorrent hue.

And all were singing lustily a song I loved to hear,  
About a little mermaid sweet with epimenorruca.

And dear old Father Neptune was explaining with his fins

The latest Dublin teaching on the management of twins.  
He handed me his trident and a long and rusty nail,  
With which to do a "Caesar" on a fat and flabby whale.

And all the mermaids crowded round and cheered me to the skies,

Tho' I couldn't find the uterus—the salt got in my eyes;  
Then suddenly they disappeared, the cause was clear to me,

A huge torrential P.P.H. had washed them out to sea.

I marsupialized the stomach, and cauterized the spleen,  
That raised a lovely hissing noise and clouds and clouds of steam.

I made a grand colostomy and decompressed the brain,  
And divided the medulla to alleviate the pain.

But now the small intestine, which I'd carefully laid aside,

Was floating on the ocean; it extended far and wide.

The whale's projectile vomiting was heard above the roar

Of its waves of peristalsis which were breaking on the shore.

And poor old Father Neptune, he was screaming mad with fear  
At the roaring borborygmi which were booming in his ear.  
And as I cut the ureters he dealt me such a whack  
On my lumbo-sacral junction which put me on my back.

\* \* \*

I found I'd fallen out of bed, my head had hit the door;  
The impact was a savage one, it shook me to the core;  
And all my lumbar vertebrae were bruised and stiff and sore,  
From hitting *Stevens's Gynæ.* which lay open on the floor.

F. W. J. W.

### AMATEUR DRAMATIC CLUB.

"ASK BECCLES."

**T** was a bold venture on the part of the Amateur Dramatic Club to select for their annual entertainment a play which had been so recently seen on the West End stage, and was therefore comparatively fresh in the memory of what was probably a large proportion of the audience. But what it was out to lose on the swings was insignificant to what it certainly made on the roundabouts. For, whatever may have happened to the memories of the audience, those of the cast served them royally, and were at liberty to be refreshed at will by a first-rate touring company in an end of London somewhat further West. In a word the venture was justified. More, it was one of the most finished amateur performances it has been our pleasure to endure. Before the curtain had been up five minutes we settled back with the comfortable realization that here were not "bricks without straw." In fact, the architecture of the plot was such that, but for the exceedingly good quality of the material, the edifice of the play could not have withstood the first puff of criticism. The plot strove to thicken, but without success—till at length its thinness became, at the naive returning of the stolen diamond, positive emaciation. Assuredly, the play was *not* the thing! But the manner of its presentation made us suffer its foolishness gladly.

The casting was admirable. Eustace Beccles, the happy possessor of a memory which must have turned many prospective visitors to Queen's Square green with envy, was played by Mr. G. P. Roxburgh with a quiet

assurance that looked as though it would gain him his heart's desire before the end of the first act. Indeed, when the saxophone and the golf club had been carefully removed from the field of action and parked in a corner, and there remained nothing but the sofa between him and the lady who, the programme convinced us, must, in the absence of other competitors, ultimately be his, we perched on the edge of our seat in a thrill of expectancy. When, a few moments later, the width of the sofa had dwindled to 3 inches of the thinnest air, we almost over-balanced. Beccles, however, retained his poise, and remembered just in time that there were two more acts to be played first, and apparently decided that Marion, acted with grace and charm by Miss Erica Lodex, was worth waiting for. We entirely agreed.

Miss Leila Alexander's interpretation of the impossible Mrs. Rivers was a gem of character study. If the action of the play ever tended to drag a little, her appearance was a tonic none could resist—we drank it down and clamoured for more. As her unwilling protégé Mr. R. M. S. Cross, who might easily and pardonably have given us a caricature of the modern lounge lizard, acted with commendable restraint, and was a lifelike and at times almost a pleasant reptile.

Mr. A. W. Spence as the villain was a nasty bit of work. (This is personal, of course, but also—high praise.) His exit from Beccles' consulting-room was masterly, and seemed to embody the spirit of many of our own "*esprits de l'escalier*." The rôle of Matthew Blaze was more than adequately filled by Mr. J. T. Hunter, who made the most of the infinite possibilities offered by the character of the Jew. Though morally satisfying, his demise was undoubtedly a histrionic loss. The part of Baki, the Hindoo servant, was admirably played by Mr. N. A. King—a careful and clever study. Several minor characters maintained the high standard of the acting, and rounded off a very pleasing performance.

The new stage, while giving more scope to the actors, had apparently refused to accommodate the scenery, and this a few hours before the first performance. New sets were obtained, as by magic, and the play, when we saw it, was capably staged. We congratulate the wizard, Mr. Nicholson, on his achievement.

The Orchestra, under the direction of Mr. Orr, played pleasantly in the intervals,

"That the time might pass more gaily,  
And the guests be more contented."

It did, and we were.

A. J. M.

[Photographs of the cast will be published in the next number.]

### ABERNETHIAN SOCIETY.

A MEETING of the Society was held in the Medical and Surgical Theatre at 8.30 p.m. on Thursday, November 24th, 1927, Mr. Wroth in the Chair.

The minutes of the last meeting having been read and confirmed, the President called upon the speaker, Prof. HARRIDGE, to deliver his address on the subject of "Sleep." The following is an abridged account:

The world is so used to regarding sleep as one of the pleasant and regularly recurring parts of the cycle of events which go to make up one day of life, and is so used to taking for granted that sleep is but a means of refreshing the tired body and mind, that ninety-nine-hundredths of its population probably never give the matter a second thought, or seek to find out the causes of its appearance. Apparently Dr. Hartridge is one of the elect of the remaining one-hundredth, and has thus been the means of introducing to us a subject which provides an interesting field for investigation.

Sleep may be said to present symptoms which resemble in many ways those found in certain pathological conditions. Thus some of its typical aspects are met with in diabetic and uramic comas, in eclampsia, in poisoning with the sulphone group of hypnotics—for example, with trional. Other drugs, such as paraldehyde, morphia, chloral hydrate and bromides produce similar effects. In carbon monoxide poisoning there is inertia, lethargy and insensibility, which in some cases terminates in death.

We do not, in the ordinary course of events, fall asleep spontaneously, but certain conditions of our bodies and surroundings predispose to the production of such a state. Of these conditions fatigue is perhaps the commonest and most generally recognized. After severe daily exercise there is a drowsy feeling which alone, or in conjunction with one or more accessory conditions, such, for instance, as a comfortable arm-chair, a dim light and monotonous low-toned sounds, soon brings about sleep. Again, the state of digestion following a heavy meal, and the taking of alcohol, may assist its onset.

A man about to fall asleep would tell you, if he were questioned, that he had certain feelings. He would say that his limbs felt heavy; that only with difficulty could he move, and that the tendency of his body was to take up a prone position. He would also notice a vagueness of ideas, and inability to concentrate, a feeling of boredom, a desire to be left alone. He would describe a heaviness of the lids, and a pricking sensation of the cornea of the eye. His head, he would say, felt heavy, and his jaw showed a tendency to open involuntarily. He would complain of feeling cold, and of having attacks of shivering.

The observer would be able to confirm many of these symptoms for himself. He would see the nodding of the head, the drooping of the lids, the drooping open of the mouth. If the man talked it would be easy to observe that if he did not actually talk nonsense, at all events his remarks lacked profundity, humour and point. He yawns. On the approach of sleep the respirations become less frequent and consequently deeper, becoming less abdominal and more costal in type.

In sleep the eyes show certain differences from the waking state. The pupils are always contracted—a behaviour which permits of distinction between real and feigned sleep. This contraction has been said by some to be caused by the upward and inward direction of the axes of the eye when asleep, but others declare that the eye axes during sleep may occupy any position. With regard to the circulatory system, we find the blood-vessels partially collapsed and the flow in them slower. The heart itself does not work so hard, its rhythm is slow, and its output per beat small. The blood-pressure falls.

Measurements of the body temperature show the cause of the feeling of coldness and the shivering, because the body temperature is found to be below the normal, sometimes as much as one degree Fahrenheit, occasionally nearly two degrees.

Determination of muscle tone shows that it is abnormally low, reflex actions are hard to elicit, are poorly displayed, and take longer than normal to commence.

During sleep the same depression of the vital functions is displayed; two, however, show enhanced activity, namely, the secretory action of the skin and the processes of digestion. With regard to the former, it is said that the amount of fluid evaporated by the skin during sleep is greater than that evaporated during the daytime, even during severe muscular exercise.

The state of coma of a sleeping man is one of very varying intensity. Suppose that a normal person has the depth of his sleep tested at various intervals after he went to bed; it is found that he is awakened easily just after falling asleep. Soon his sleep is more profound, and greater difficulty will be found in rousing him, until, about two or three hours later, the depth reaches its maximum, following which it decreases till about the sixth hour, after which the intensity of sleep is almost uniform. Just before the person wakes in the morning the depth of sleep increases slightly for a short time, and finally, decreasing, disappears.

Numerous experiments have been performed to test the varying degrees of response to external stimuli during sleep. A delicately modulated musical instrument, with increasingly loud tone, will determine the strength of sound necessary to awaken a subject, the sense of touch may be determined by pressure, and that of smell or taste in an obvious manner, during the different periods of sleep.

Only three parts of the mechanism of the body are never rested by sleep. These are the respiratory system, which evidently is indispensable, the heart, and the vascular motor system—that is, the apparatus for the supply of oxygen to the tissues is in constant action all day and all night.

Various theories have been advanced to explain sleep and its attending phenomena. Thus, in 1860, Durham investigated on a dog the effects of sleep on the body processes. In 1881 Mosso did some similar experiments on human beings. The hypothesis which resulted from these investigations was that sleep is caused by a diminution in the blood-supply to the brain, due to (a) the diminished output of the heart, and (b) to the increased flow of blood through skin and viscera.

Some confirmation of this hypothesis is obtained in the fainting which follows the cerebral anaemia produced by the abolition of the controlling influences of the central nervous system on the blood-pressure and the taking up of an erect posture. Thus in man and other animals the raising of the head above the level of the trunk is accompanied by a constriction of the blood-vessels of the viscera. The rise of blood-pressure which this produces increases the supply of blood to the brain. In particular the splanchnic nerves may be mentioned as bringing about a constriction of the blood-vessels when they are stimulated. If, however, the splanchnic nerves are cut, these changes cannot take place. The result of such an operation is well shown in the case of a late laboratory cat, which, with severed splanchnic nerve, suffered from an inhibition of the blood supply to the brain when its head rose much above the level of its body. For this reason fainting fits often occurred, and were cured by the drastic and picturesque remedy of holding it up by the tail to cause an increased flow of blood to the head. Such a state of affairs was too good to last, and the unfortunate cat, after some years, met its fate by its own audacity. For, on trying to climb a long staircase in search, presumably, of a mouse, when no first aid was at hand, it stuck half-way and fainted, thus surrendering at length the last of its spare lives.

Another theory has been that the fall of temperature of the body brings about a corresponding depression in the activity of all body processes, while another claims that the diminished tone of the body muscles is responsible for sleep by causing the temperature to fall, which affects in its turn the rest of the body as before, and causes sleep. Another suggestion is that the changes begin with the heart, and follow the same course as those just given. Two other theories, one histological, the other biochemical, suggest that the sequence begins only at the central nervous system itself. Lastly, some physiologists consider that sleep is just one part of the natural course of events in the life of the body, and, irrespective of outside or inside changes, must come. This is referred to as the "rhythmic theory." It is difficult to decide which point of view is likely to prove most correct, though the first four all have the same fundamental basis, differing only in the opinion as to which organ is the first to begin the events leading up to sleep.

Lastly, it may be asked why we do not consider sleep as a pathological rather than as a physiological condition. A moment's thought would give the questioner a satisfactory answer. Our own experience surely tells us that whereas disease leaves us debilitated and weak, sleep, on the other hand, is the best means of refreshing and resting the body.

The lecturer then dealt with drugs which induce and inhibit sleep, and finished by considering the causes and treatment of insomnia.

The vote of thanks for the very interesting and entertaining address, proposed by Dr. REEVES and seconded by Mr. WOODROW, was carried with acclamation.

In replying, Dr. HARRIDGE gave examples of the extreme shortness of time during which the action of a dream took place.

The meeting was then adjourned.

## STUDENTS' UNION.

## RUGBY FOOTBALL CLUB.

## ST. BARTHOLOMEW'S HOSPITAL v. BRADFORD.

Played on January 17th. As usual before our home matches, it began to rain about an hour before the start and continued throughout the game. We were without Gaisford, Jenkins, Bettington, Capper and Briggs, while Bradford had their right wing pair, Roberts and Tetley, away playing for Vorkshire.

The Hospital started off with the wind, and the forwards, being well both from the loose and the tight, our backs had many chances of attacking, and within eight minutes Guinness scored from a return pass from Prowse. Shortly afterwards Guinness and Prowse repeated this manoeuvre, but after evourcing past the full back, Guinness gave a bad pass inside instead of going on himself. Just before half-time both sides narrowly missed kicking a penalty goal.

The Bradford forwards pressed hard in the second half, but our defence was very sound and never allowed their backs to go far. Taylor broke away inside our "25" and passed to Knox, who was supporting him; the latter drew the full-back and gave Grace a clear run in from half-way, Guinness converting. The condition of the ground was now very bad, and the play was confined to the forwards, while Taylor continually gained ground by his kicking. Just before the end Bonner kicked a penalty goal for Bradford for offside.

Evans at full back had little to do, but saved well from the Bradford forwards on two or three occasions. Prowse and Guinness again proved to be a very good combination on the left wing. Grace had few chances, but ran with good combination when he did get the ball, while his defence, as usual, was faultless. Beilly opened up the game with perfect passes and cut through well on occasion while Taylor can seldom have played better. Often doing the unexpected in attack, he was most useful in getting back to defend. The forwards, although overweighted, held their own, and had more than their share of the ball; Williams was ubiquitous, W. J. Taylor did well in close play, and Knox, playing wing forward for the first time, played an extraordinarily good game.

St. Bartholomew's Hospital, 1 goal, 1 try (8 pts.); Bradford, 1 penalty goal (3 pts.).

Team: W. E. F. Evans (*back*); A. H. Grace, G. F. Petty, H. W. Guinness, C. B. Prowse (*three-quarters*); F. J. Beilly, J. J. Taylor (*halves*); R. N. Williams (*capt.*), H. D. Robertson, V. C. Thompson, H. G. Edwards, F. C. V. Scovell, J. S. Knox, W. J. Taylor, J. M. Jackson (*forwards*).

## ST. BARTHOLOMEW'S HOSPITAL v. COVENTRY.

January 21st. This game was played at Winthorne Hill on an extremely heavy ground. We have seldom, if ever, seen such a good game in such conditions. Coventry won by the only try scored, though both sides came near to scoring on numerous occasions. Beilly was unable to play for the Hospital owing to an injured knee. The game started at a terrific pace, the back divisions of both sides bringing off several good passing movements. The forwards were doing great work as well, and R. N. Williams led some splendid rushes. Coventry's try came towards the end of the first half, their scrum half getting over from a scrum near our line.

The second half was almost a repetition of the first, except that the ground had become churned up and the going was therefore even more heavy. There was no score in this half, but we had rather more of the play, and had Petty passed as well as he ran and tackled Grace might have scored. The forwards played splendidly, the pack working together as a whole. In the set scrums the packing and heeling were the best we have seen this season, and they brought off many excellent dribbles. All played well, but we noticed particularly R. N. Williams, Robertson and Knox. Taylor at scrum-half played another very good game. The way in which he has adapted himself to this position is a great credit both to himself and to those who thought of playing him here. Guinness was good, but he does not set his three going well. Grace did all he could extremely well, but he was starved. Gaisford played out of his good games, except that he missed the touch line too often—a sin always, but a crime on a ground such as this game was played on.

The side has come on wonderfully well since the beginning of the season, and is now well equipped in all departments except in the centre of the three-quarter line. With Beilly at fly-half, though, we can have one good centre in Guinness. We consider that every effort should be made to give Grace every possible chance, instead of, at the moment, the fewest possible. Grace is a good wing, and we believe that he will repay the side for playing him.

Team: W. F. Gaisford (*back*); A. H. Grace, G. F. Petty, E. U. H. Pentreath, C. B. Prowse (*three-quarters*); H. W. Guinness, J. T. Taylor (*halves*); R. N. Williams (*capt.*), C. R. Jenkins, R. H. Bettington, W. M. Capper, J. S. Knox, H. D. Robertson, W. J. Taylor, V. C. Thompson (*forwards*).

P. G. LEVICK,  
*Hon. Treasurer.*

## HOCKEY CLUB.

## ST. BARTHOLOMEW'S HOSPITAL v. R.N. (CHATHAM).

The 1st XI commenced the second half of their fixture list by visiting Chatham on January 14th. Unfortunately Attwood, Church and Windle were unable to play, and in addition Sinclair has left the Hospital to do a house appointment at Coventry. Sinclair has for some time been a great source of strength to the team and his loss will be greatly felt. Snell, Iliff, Hodgkinson and Neill came into the side.

The ground proved to be in excellent condition and a fast game resulted, the Hospital giving what was, in the circumstances, their best display of the season.

Playing against a strong wind in the first half Bart's went off at a great pace, and, after a good attacking movement, Francis, playing at centre-forward, opened the scoring. Soon afterwards Hartley, playing at centre half in this match, scored from the edge of the circle. Chatham now began to do some attacking, and although Bart's still had the best of the game, the score at half-time was 2-2.

After the interval Chatham put in some dangerous rushes to the Hospital circle, but they were slow in front of goal, and with Wright and McCoy getting through a lot of work at back, they failed to add to their score. Symonds and Iliff each scored a goal for Bart's, the latter's effort showing the usefulness of following up on to the goal-keeper when another forward has put in a shot.

The whole team played well, but special mention must be made of the wing halves, Snell and Fordham, who were excellent. The forward line played with method, and Neill, well supplied with passes by Symonds, improved a great deal on his previous displays for the 1st XI.

Team: H. L. Hodgkinson (*goal*); F. H. McCoy, P. M. Wright (*backs*); V. C. Snell, K. W. D. Hartley, M. S. M. Fordham (*halves*); E. J. Neill, J. C. W. Symonds, R. H. Francis, A. D. Iliff, A. G. Williams (*forwards*).

## UNITED HOSPITALS HARE AND HOUNDS.

On Wednesday, November 30th, at Hayes, v. South London Harriers, "A" team. The Hospitals lost by 1 point to a strong team, the score being 2 to 28.

## ORDER OF FINISHING.

1. A. W. B. Tebbutt	S.L.H.	20 min. 57 sec.
2. E. P. Kailton	S.L.H.	30 .. 25 ..
3. E. J. Somerset	King's	30 .. 35 ..
4. H. C. Harley	St. Mary's	30 .. 38 ..
5. H. S. Irvine	S.L.H.	30 .. 45 ..
6. J. S. Horsley	London	30 .. 52 ..
7. P. Forsythe	St. Thomas's	30 .. 55 ..
8. H. B. Lee	Bart's	30 .. 56 ..
9. L. A. Pool	S.L.H.	31 .. 10 ..
10. C. B. E. Morgan	S.L.H.	31 .. 12 ..

Points.—South London, 1, 2, 5, 9, 10 = 27.

Hospitals, 3, 4, 6, 7, 8 = 28.

Wednesday, December 7th, v. Blackheath Harriers "A" team. This match was lost by 41 points to 39 at Hayes over the 5-mile course. H. C. Harley (St. Mary's), while leading by about a quarter of a mile, unfortunately took the wrong course.

## ORDER OF FINISHING.

1. H. S. Smith	Blackheath	29 min. 30 sec.
2. T. A. R. Callendar	London	29 .. 35 ..
3. J. S. Horsley	London	29 .. 44 ..
4. I. and H. B. Lee	Bart's	29 .. 44 ..
5. J. D. Rogers	Blackheath	30 .. 3 ..
6. G. J. Richmond	Blackheath	30 .. 12 ..

Points.—Blackheath 1, 5, 6, 7, 8, 9 = 36.

Hospitals: 2, 3, 4, 10, 11, 12 = 42.

The 7-mile handicap will be run on Wednesday, February 1st. Fixtures for February are: 15th, v. Orion Harriers "A" team; 22nd, v. Cambridge University Hare and Hounds.

R. R. RACE, *Hon. Sec.*

## CORRESPONDENCE.

## THE TRUSTWORTHINESS OF THE BIBLE.

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

DEAR SIR.—We would like to draw the attention of your readers, by a series of letters in your columns, to the evidences of Christianity especially with regard to the Bible on which we, as a Union, base our work.

Yours very sincerely,

H. W. GUINNESS,  
*President.*

St. Bartholomew's Hospital,  
London, E.C. 1;  
January 20th, 1928.

"What the heart of a fortress is to its outworks and minor defences, that, to the Christian Faith, is the Bible—its central stronghold. To give up that, in any measure, is, therefore, in so far, to yield up the whole fortress to the foe."

"If the Bible be a divine book, it has nothing to fear from rational inquiry. Investigation will issue in vindication, and the more searching the investigation, the more triumphant the vindication." "God never meant that the believer's confidence in His Word should be a blind bigoted assumption of what is unproven, hiding behind ignorance, tradition or superstition."

"What do you believe?" asked Whitefield of a worker in the coal-pits of Cornwall. "What the Church believes," was the answer. "And what does the Church believe?" "What I believe." "And what do you both believe?" "The same thing."

No! God wants us to use the intelligence He has given us, think out this miracle of books. "For it neither befits nor belongs to the infancy of the race, and yet it was found among men in the early days of the world's history; and, with all the boasted learning and wisdom of the twentieth century, it still defies all competition."

"One of its most important features is its UNITY, which is as marvellous as it is conspicuous. Every circumstance connected with its preparation and production was calculated to prevent such unity. Here are sixty-six different books, written by some forty different authors, in three different languages, and the periods of authorship cover a score or more of centuries. These human writers were brought up in different countries, and were so remote from each other in time and space that they could have had no mutual acquaintance, and could neither have conspired for an evil end, nor combined for the best purpose. The subjects on which they wrote were very diverse and various, some historical, some prophetic, some devotional, some ethical. And yet, notwithstanding all these divergent elements, they have produced essentially one book."

"Certain conspicuous conceptions or ideas pervade the whole Book, like golden cords on which all else is strung—such as the ideas of the Kingdom of God, sin and salvation, sacrifice and priesthood. Many of these conceptions are so lofty and unique in sublimity and novelty that it is impossible to account for them on any human theory. They are not the products of the times in which these men wrote, nor are the like found in other literature of those or subsequent periods."

"The unity of the Bible is absolutely unique. Never elsewhere have so many different treatises, historical, biographical, ethical, prophetic, poetical, been combined together, making one book, as all the bones, muscles and ligaments combine in one body."

"What wonder is it if the believer feels that, even considered as a literary product, this Book is Divine."

(See Dr. A. T. Pierson's book, *God's Living Oracles*, Pickering & Inglis, 3s. 6d.)

## THIS IS THE BED THAT STALLARD MADE.

[Out of the chaos of criticism evoked by our correspondent's articles, the following is the only reply that can be considered official as having been sent for publication. With the same impartial attitude which made us print that article we print here—the reply.—Ed., S. B.H.J.]

This is the cushion that lay on the bed that Stallard made. This is the air that filled the cushion that lay on the bed that Stallard made.

This is the pump that blew in the air that filled up the cushion that lay on the bed that Stallard made.

This is the window that looked at the back as it lay on the cushion filled with the air blown in by the pump that lay on the bed that Stallard made.

This is the pin that let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made.

This is the night pro, so scared that she screamed "Oh!" when

she saw the great pin make a hole in the thing and let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made.

This is the nurse who left her alone while she went to the 'phone to tell the Night Sister she thought 'twas a blister when she stuck in the pin that let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made.

This is the Night Sister who called up the House Myster to come tend the blister pricked by the pin which let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made.

This is the trolley, all ready, how jolly, So said the House Myster with aid of Night Sister and strapping of Lister I'll soon mend that blister pricked by the pin that let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made. NUF SED AND SO TO BED.

## REVIEWS.

THE SURGICAL TREATMENT OF MALIGNANT DISEASE. By SIR HOLBURN J. WARING. (Oxford University Press: Humphrey Milford.) Pp. 607. 19 Coloured Plates and 277 Illustrations. Price 50s.

"The Surgery of Malignant Disease," by our Senior Surgeon, is a book of outstanding merit, and one which reflects distinction on our Hospital and College.

The Bradshaw Lecture of 1921 forms the basis of the work and acts as an introductory chapter. Although commenced several years ago the whole book has been brought thoroughly up to date, and no recent advances in surgical or scientific work pertinent to the subject have been omitted.

The arrangement of the chapters seems a little curious; the neoplasms of bone are not grouped together, and the liver and gall-bladder are separate from the alimentary system.

The principal pathological features of each condition are described, and an account given of the symptoms and signs with a brief reference to the differential diagnosis. The treatment recommended is in the main operative, especially in all early cases. The possibility of the use of radium is suggested in certain situations, particularly in reducing the size of a growth, as a palliative or a pre-operative measure. The surface application of radium is strongly condemned. The use of deep X-ray therapy is discussed in each section, but the author has formed an unfavourable opinion of this form of treatment. Full statistics are given of the results of treatment, taken from the records of St. Bartholomew's and from the general literature. An unusually full bibliography is given.

A few "benign inexactitudes" occur. Fig. 98 represents a lymphadenoma, not a sarcoma of the spleen; Fig. 200 a sarcoma of the retro-prostatic tissues. The author does not recognize the spermatogenic variety of carcinoma of the testis, the so-called spermatocytoma, but Fig. 92, described as sarcoma of the testis really illustrates this condition.

The book is exceedingly readable, and the student could well resort to it as a refreshing change from the average text-book. The only dull pages are those devoted to a discussion of statistics.

The publisher is to be congratulated on the production; it is the most profusely and best illustrated book we have seen. Although the price is 50s., which is usually considered to be somewhat excessive, in this instance we have no hesitation in affirming it to be money well spent.

ADVANCED METHODS OF MASSAGE AND MEDICAL GYMNASTICS. By SARLES AND WOOD. (London: Faber & Gwyer, 1927.) Price 5s.

Often in reading a new book on massage and medical gymnastics, one experiences a feeling of disappointment at finding it in nearly all respects except the accidents of wording and expression the counterpart of its predecessors.

To a large extent this must necessarily be so in a book which aims at including in 200 or so pages treatment for all the disabilities and diseases which now come within the sphere of the medical gymnast. A book would be welcomed giving fuller information in the light of experience of one or two special subjects. At the present time, when such a large proportion of cases under treatment are those of rheumatoid arthritis, one looks for some fresh light and help in methods, e.g. in dealing with resultant deformities. Also—for instance, in pes cavus—One always hopes for a new invention in stretching apparatus. But while new methods would be welcomed, perhaps what is more necessary is the presentment of known methods in clear, concise form, with the emphasis stressed on important points. The book under review (while not neglecting new methods,



e.g. the pulley) owes much of its value to its extreme clearness and sense of proportion, its excellent arrangement of exercises in progression and its insistence on fundamental points, which, while known in theory, are not always remembered in practice; for example, the importance of the straight foot in walking for flat foot, the short step in walking after Pott's fracture, the effects of badly-made shoes, the necessity of teaching correct nose blowing and breathing to the child. It is good to see such necessary prominence given to the science of muscle re-education. The importance of early massage and treatment of fractures in the neck of humerus and Colles's fracture is emphasized.

The chapter on pulley and sling exercises is very interesting, and calls for study with regard to stiff joints, and especially to anterior poliomyelitis.

This book ought to prove of great value to the medical student—who will find the diagrams explain the exercises when medical gymnastic terms might not be understood; to the massage student and also to the advanced masseuse, who has in it an up-to-date, reliable book, on to which she can link the results of her own experience.

**EXPERIMENTAL PHYSIOLOGY.** By Sir EDWARD SHARPEY-SCHAFER, F.R.S. Fourth edition. (London: Longmans, Green & Co., 1927.) Pp. 130. 62 Illustrations. Price 6s. net.

The fourth edition of this well-known and widely-used handbook quite maintains the excellent standard set by the earlier editions. It may be safely said that the book is indispensable to the student of experimental physiology.

A certain amount of new material is included; in this connection may be mentioned the measurement of chranaxy, which term, one is glad to note, the author Anglicizes.

In one or two instances the descriptions might well be amplified, e.g. in the case of colour-vision, and the scope of the book would be increased were more stress laid upon the application of the experiments to elementary human physiology.

It may be mentioned that a stereoscopic microscope is not necessary to observe the circulation in human capillaries; there are on the market several good makes of skin microscope which function admirably, and some of which have been for years in use at this hospital.

If the author had seen his way clear to include in the volume a series of typical tracings obtained in the various experiments, the value of the book to the average student would have been much enhanced, and the incorporation of an index would add materially to facility of handling, both by teachers and students.

**DIAGNOSIS AND TREATMENT IN DISEASES OF THE LUNGS.** By P. E. TYLCOOTE and G. FLETCHER. (Humphrey Milford, Oxford University Press.) Pp. 270. Price 7s. 6d. net.

This is a very practical manual, intended for the "senior student or the young practitioner." The authors have thoroughly succeeded in concentrating on points of difficulty in diagnosis, and have been generous with prescriptions and other hints for treatment that they have found valuable. The book seems most useful where it deals with bronchitis, pleurisy, pneumonia and the like, and is admittedly very sketchy about pathology in general and the rarer conditions. This is compensated for by sound premises and logical reasoning. Points stressed are the importance of a change of air to avoid chronicity after an attack of acute bronchitis or where the discharge from an empyema persists; and the fact that reliance must be placed on no single physical sign, since the advent of X-rays has proved the soundest diagnoses false. The most inadequate part of the book, however, is that dealing with the treatment of pulmonary tuberculosis, and especially with the symptoms of hæmoptysis. The administration of morphia is laid down without any consideration for opposing views. The book is light and very readable.

#### CHANGES OF ADDRESS.

BROOKE, J. R., "Wood Lawn," Thatcham, Newbury, Berks.  
BERRY, SIR JAMES, Bramblebury, Dunsmore, near Wendover, Bucks. (Tel. Wendover 43.)  
BRAMBRIDGE, C. V., The Native Hospital, Mombasa, Kenya.  
BROOKE, C. O. S. B., Tuberculosis Dispensary, 6, Glebe Street, Stoke-on-Trent.  
BURNE, T. W. H., Chief Surgeon's Quarters, Ipoh, Federated Malay States.  
BUTTERY, J. W. D., 1, Grimston Avenue, Folkestone.  
DOWELAN, C. J., Flat 3, 9, Roxborough Park, Harrow-on-the-Hill.  
GILLON, G. G., 70, Wimburne Road, Poole, Dorset.  
GOSSE, P., Saville Club, 69, Brook Street, W. 1.  
MARTIN, T., Eastgate, Tottenham, Kent.  
ROBB, W. A., 25, Harley Street, W. 1. (Tel. Langham 1895.)

#### APPOINTMENTS.

BROOKE, C. O. S. B., M.R.C.S., L.R.C.P., D.P.H., appointed Tuberculosis Officer for Stoke-on-Trent.  
BURN WHITE, H., M.D., F.R.C.S., appointed Assistant Obstetric Surgeon to the City of London Maternity Hospital.  
DOWELAN, C. J., M.R.C.S., L.R.C.P., D.P.H., appointed Assistant Medical Officer to the Surrey County Council.  
NOON, C., F.R.C.S., appointed Hon. Surgeon to the Patrick Stead Hospital, Halesworth, Suffolk.  
NORRISH, R. E., M.R.C.S., L.R.C.P., appointed House Surgeon to the Royal Northern Hospital, Holloway, N.

#### BIRTHS.

DALL.—On January 22nd, 1928, at "Redcroft," West Wickham, Kent, to Harold C. J. and Kate Douglass Ball—a son.  
CAFENER.—On December 2nd, 1927, at Ann Arbor, Michigan, U.S.A., to Marion (née Clarke), M.R.C.S., L.R.C.P., wife of Norman Capener, F.R.C.S.—a daughter.  
DOYLE.—On January 10th, 1928, at 130, Old Bromley Road, Bromley, to Gladys, the wife of Dr. J. L. C. Doyle—a daughter.  
EDWARDS.—On January 22nd, 1928, to Eve, wife of A. Tudor Edwards, F.R.C.S., of 20, Queen Anne Street, Cavendish Square—a daughter (stillborn).  
GAMBHAM.—On January 14th, 1928, at Kisumu, Kenya, to Dr. and Mrs. (née Long Price) P. C. G. Gambham—a daughter.  
GILBERTSON.—On December 21st, 1927, at 20, Bancroft, Hitchin, Herts, the wife of Dr. H. Marshall Gilbertson, of a daughter.  
HERINGTON.—On December 24th, 1927, to Dr. and Mrs. Cecil Herington, of Ilkerton, Derbyshire—a daughter.  
LANDAU.—On December 26th, 1927, at 28, Western Road, Penang, to Marjorie (née Gubbay), wife of Dr. J. V. Landau—a daughter.  
MALTY.—On January 3rd, 1928, at 56, Rectory Road, N. 16, to the wife of Dr. H. Wingate Maltby, M.C.—a son.  
SIMPSON.—On January 15th, 1928, at her father's house, Campden Lodge, W., to Joyce Rayner (née Batten) and Reginald Hugh Simpson—a daughter.  
YOUNG.—On December 22nd, 1927, at a Bournemouth nursing home, to Olive, wife of S. L. O. Young, M.D., of Wood End, Yarmouth, I.W.—a son.

#### MARRIAGES.

BROOKE MASTERS.—On January 10th, 1928, at Budbrooke Church, Warwickshire, James Robert Brooke Masters, B.S., of Thatcham, Newbury, Berks, only son of Mr. and Mrs. A. Beagley, of 50, Bushmead Avenue, Bedford, to Dora, daughter of Mrs. John Masters and the late Mr. John Masters, of Southam, Warwickshire.  
BUTTERY—SMITH.—On January 24th, 1928, at the Oratory, Hagley Road, Birmingham, John Wilfrid Douglas Buttery, late of Durban, S. Africa, to Dorothy Marie, eldest daughter of Dr. Percy Smith, of Edgbaston, Birmingham.  
HIGGS—HOWARD.—On December 24th, 1927, at St. James's, Norland Square, Sydney Howard Higgs, F.R.C.S., 1A, Portland Place, W., to Betty Howard, 41, Addison Avenue, W., widow of Arthur Howard.

#### DEATHS.

DUCKWORTH.—On January 20th, 1928, at 28, Grosvenor Place, S.W., Sir Dyce Duckworth, Bt., M.D., LL.D., F.R.C.P., son of the late Robinson Duckworth, of Liverpool, aged 87.  
HINE.—On December 26th, 1927, William Conway Hine, M.R.C.S., of Dunain, Parkstone Road, Poole, Dorset, aged 85.  
KING.—On January 17th, 1928, at Croydon, after an operation, Sir George Anthony King, Chief Master of the Supreme Court Taxing Office, aged 69.  
LANG.—On January 18th, 1928, Basil Thorn Lang, F.R.C.S., Surgeon to the Royal London Ophthalmic Hospital, Moorfields, beloved husband of Nora Lang, and only son of William Lang, F.R.C.S., of 22, Cavendish Square, W. 1, aged 47.

#### NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEWS HOSPITAL JOURNAL, St. Bartholomew's Hospital, E.C. 1.

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., at the Hospital.

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0510.

# St. Bartholomew's Hospital



## JOURNAL.

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

VOL. XXXV. No. 6.]

MARCH 1ST, 1928.

PRICE NINEPENCE.

#### CALENDAR.

Fri., Mar. 2.	—Sir Percival Hartley and Mr. L. B. Rawling on duty.
Sat., " 3.	—Rugby Match v. Rosslyn Park. Home. Hockey Match v. Old Chislehamians. Home. Association Match v. Old Cholmelians. Home.
Mon., " 5.	—Special Subject. Clinical Lecture by Mr. Elmslie.
Tues., " 6.	—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
Wed., " 7.	—Surgery. Clinical Lecture by Mr. Harold Wilson.
Fri., " 9.	—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Sat., " 10.	—Rugby Match v. Moseley. Away. Hockey Match v. St. Lawrence College. Away. Association Match v. Maximum A.F.C. Away.
Mon., " 12.	—Special Subject. Clinical Lecture by Mr. Rose.
Tues., " 13.	—Prof. Fraser and Prof. Gask on duty.
Thurs., " 15.	— <b>Abernethian Society: Terminal Sessional Address by Sir Frederick Andrewes, at 8.30 p.m.</b>
Fri., " 16.	—Dr. Morley Fletcher and Sir Holburn Waring on duty.
Sat., " 17.	—Rugby Match v. London Scottish. Home. Hockey Match v. Old Felstedians. Home. Association Match v. Old Owen's. Away.
Mon., " 19.	—Special Subject. Clinical Lecture by Mr. Just.
Tues., " 20.	—Sir Percival Hartley and Mr. L. B. Rawling on duty.
	<b>Last day for receiving matter for the April issue of the Journal.</b>
Fri., " 23.	—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
Sat., " 24.	—Rugby Match v. Northampton. Home. Association Match v. Radnic A.F.C. Away.
Tues., " 27.	—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Fri., " 30.	—Prof. Fraser and Prof. Gask on duty.
Sat., " 31.	—Rugby Match v. Plymouth Albion. Away. Hockey Match v. Guy's. Away.

#### EDITORIAL.



URMURING voices have come up to our Olympian ears that there is a complaint among the helots that this JOURNAL was a week late last month. What of it? We received a fortnight ago the newly published November number of the *St. Thomas's Gazette*. Thus arises an interesting problem

—if a November issue issues in February, when does the next issue issue? We anticipate being hooted when this present number appears on time as it is sure to do. On second thoughts we'll make it a day late.

But it is indeed gratifying that people take notice, if not of our last day for receiving matter, at any rate of our first day for disgorging it. Shaving paper is scarce. A young fellow interested in some game or other came to us to-day and lisped, "Pleathe could you tell me the last day you receive matter?"—to-day, when everything except this Editorial is in print and the printers are howling at the gate.

\* \* \*

Guy's have been squarely defeated by Williams and his Troops—a fact which we believe has confounded the public and caused them to wonder considerably. Now for the London!

\* \* \*

Another infallible cure for a disease has been accorded the dignity of an exordium in the columns of the daily press. It would be interesting to inquire into the process whereby the guarded statements of research workers made to journalists are turned into further evidence of the all-conquering spirit of mankind in its winning battle with Nature.

*B. lepræ*, we feel, will not be considerate of the feelings of Fleet Street.

Let us hope that these "combined" voices will be justified in adopting their tone of ringing, all-British certainty.

\* \* \*

We notice also in the press a growing tendency towards a use of the personal column of the *Times* by agitated patients, who write: "Oxophthalmic goitre: Glad to hear first-hand of symptoms, chance of cure, and how long an attack lasts"—or words to that effect. A magnificent chance for the coming specialist to write

fictitiously and recommend his own medicine. Not, however, a healthy tendency on the whole!

\* \* \*

Mr. W. McAdam Eccles has been elected Consulting Surgeon to and a Governor of St. Bartholomew's Hospital. He has been, in addition, appointed an Examiner in Surgery in the University of Glasgow.

\* \* \*

We congratulate Mr. Harold Wilson, M.S., F.R.C.S., on being appointed Surgeon, and Mr. G. L. Keynes, F.R.C.S., Assistant Surgeon, to the Hospital. New Surgical Out-Patient days are: Mr. Vick, Wednesday, and Mr. Keynes, Saturday. A full list of times of attendance of Out-Patient Physicians and Surgeons will be published in the April number.

\* \* \*

The subject of this month's prize essay, which has been side-tracked of late for space, will be—"The Potential Dramatics of Consultations," or "New Symptoms Required: Doctors Tired of Old Ones."

\* \* \*

#### ST. BARTHOLOMEW'S HOSPITAL WOMEN'S GUILD.

The St. Bartholomew's Hospital Women's Guild would like to take this opportunity of announcing that they are forming a Junior Branch in connection with the above Guild.

They have long felt that it is most important that they should arouse and obtain the early aid, where possible, the active interest and help of the many children and young people who are at present only connected indirectly with the Hospital, and of course their friends. To all of these they wish to extend a very cordial invitation to come and join this new Branch, which is to be called the "Bart.'s Busy Bees," and to help in the work that is being done.

In support of this scheme the Lady Mayoress has very kindly promised to give an Inaugural Party, to be held at the Mansion House on Saturday, April 28th, when details of the future plans and aims of the Branch will be announced.

The Guild would be very grateful if the readers of this JOURNAL would give their support to this new endeavour by telling their young friends and relations about it and persuading them to join.

Any further information, or the leaflet about the "Bees," will be sent with pleasure to anyone applying to the Secretary of the "Bees," Mrs. Geoffrey Evans, 23, Park Square, N.W. 1, or to the Guild Sec., Mrs. Barris, 50, Welbeck Street, W. 1, to either of whom the names of anyone wishing to join should be sent as soon as possible.

## THOSE OTHER PRACTITIONERS.

(Being part of the Mid-Sessional Address to the Abernethian Society by the RT. HON. LORD DAWSON OF PENN.)



**FREELY** admit that this title suggests various other connotations. To the Bart.'s man it may suggest all those who do not belong to Bart.'s!

And although my Greek, I admit, is getting a little grey, and I hope someone here will correct me, I have the impression that the Athenians styled all those who did not belong to Attica as *Ξῶποι*. Well, now, a Bart.'s man is quite right; he does think that there are people who belong to Bart.'s, and people who do not, and it is an implication you all convey, so surely, albeit so delicately and yet really in so rightful accord with your great and ancient traditions, which are just as much a part of the history of this city as London is the mirror of England's history.

My intention, however, was to refer to those practitioners who do not give allegiance to the medical profession, and are styled "unqualified." That such should have existed in past centuries does not cause us surprise, but that their activities should show so little sign of abatement in these days does prompt us to some reflection. Now a quack may be described as "a man who makes baseless and boasting pretensions for a method of treatment." He may be one who deceives himself before he deceives other people, or he may belong to that other group of men who deceive other people without deceiving themselves. We can find a parallel for the former in the career of a great statesman. At one time that wonderful commentator on human affairs, Mr. Henry Labouchere, said, "I do not so much mind Mr. Gladstone having an ace of trumps up his sleeve, but what I do object to is when he says that God put it there."

Now we must honestly admit that the quack may equally well exist within the boundaries of the profession as outside it, though we do not emphasize that outside these walls. For my present purpose I exclude from my purview all those who have the intention to be impostors, and whose methods are designedly dishonest.

The unqualified or irregular practitioner need not be a quack. He need not be somebody who, as I put it just now, "makes pretensions which are baseless and boastful." In some instances his methods of treatment are sound, and not only sound but helpful, provided that they are applied in the right directions. From that remark you will see that I am trying to approach this question with independence of spirit.

To keep the art of medicine firmly set upon the rock

of knowledge and to defend it against false doctrine, what vantage grounds should we select? I suggest to you that we should take our stand on diagnosis. Here our position is unassailed. To attempt to treat disease without knowing what is wrong would be folly. Diagnosis must precede treatment, and the knowledge of diagnosis can only come from years of training in the sciences of physics, chemistry, biology, anatomy and pathology, and, later, in the study of the bodies and minds of patients in the wards. However public opinion may be carried away, as it undoubtedly is carried away, by this or that cult or miraculous cure, and however much the public may demand of us to take the exponents of the cult to our bosoms (and they ask it for a different set two or three times a year), they would never give the independent practitioner the rights and duties of medical men any more than they would give a heaven-sent, though untrained engineer, the right to carry them on a railway train or to act as engineer of a steamer across the Atlantic. You will always find that if that is put up to the public, you may be quite sure what the answer would be. In other words, if we wish to defend the rightful position which knowledge alone should hold, it is folly for us to waste our time with treatment and disputes on the questions of treatment, whether one is right and the other is wrong. Our only vantage ground is diagnosis. You cannot treat a case until you know what it is, and you can only know what is its causation after years of training, not in medicine alone, but in all the sciences upon which medicine is based. I therefore urge you in any conflict that comes in your path—and conflict is bound to come—to take your stand on diagnosis.

On the other hand, it must be freely admitted that treatment is not the appanage of the medical profession alone. The art of healing has in all ages been the concern of peoples, and has been blended with their desire to help and to save. Its instinctive promptings exist in every individual, man and beast; witness the dog who licks the inflamed paw, and who shows a selective intelligence in the way in which he chooses the grass he shall eat. If we go back into former ages we see how the apothecary and the village dame gathered from the countryside the herbs and simples which public opinion held would be of use in curing the sick. The herbalist, when he was gathering the wood anemone, used what was almost a ceremony of ordination. As he picked it he would say: "I gather thee as a remedy against all disease." There was a similar ceremony attaching to the collection of rosemary, which, as you know, was a very favourite drug in times gone by, but I cannot help thinking that that ceremony must have been due, partly, at any rate, to the fact that rosemary was

frequently added for the purpose of flavouring ale. The Druids called mistletoe "all-heal." This object is attained in these days by suspending mistletoe in our rooms at Christmas time. Curiously enough we use mistletoe to-day to lower blood-pressure, whereas I think you will agree with me that by its ceremonial use blood-pressure is likely to be raised!

Nor did surgery even escape the influence of popular belief. You in this Hospital would think that the making and unmaking of noses would be a skilled and unromantic craft, associated with plus 4 at golf. Yet the learned Gaspar Taliacotus, a renowned professor of physic and surgery in the sixteenth century at the University of Bologna, is credited with this useful invention. The material for the construction of these noses was taken from the rearmost part of the animal economy of a penniless martyr hired for the purpose—the nearest approach to the "donor" in modern transfusion. So strong was the sympathy between the graft and the parent stock that if and when the martyr died, the nose fell off at the same time. I can only add that were this to happen under the modern conditions of this Hospital, it would not occur a second time!

If we survey the field of treatment to-day, we find it on the one hand adjacent to the exact sciences of anatomy, physiology, pharmacology and chemistry, but in other directions, on other aspects, it merges with the ill-defined territories of mind, feeling, faith and even superstition. Now all of these penetrate far back into time and human associations. That medicine should have as one of its styles and titles "the art of healing" reminds us that for the public the main purpose of our existence is to make suffering people well.

From the innumerable cults and cures, past and present, I will select a few examples.

Elisha Perkins, in the eighteenth century, was during the earlier part of his career a country practitioner. Later he invented the "metallic tractors," which consisted of two rods, one rod being made of gold, copper and zinc, and the other made of silver, platinum and iron. These rods were drawn over the affected part and actuated by the electricity they were alleged to produce; they cured most things—rheumatism, pleurisy, boils and every kind of nervous disease. Their vogue was great. They took possession of public opinion in the same way as football and cricket matches take possession of ours. They brought all ranks of society under their spell, including statesmen, noblemen, divines—who in those days occupied places of far greater influence than they do to-day. Real cures did result, and we must not ignore that fact. Then came the decline, and finally a Dr. Haygarth, of Bath, had some tractors made of wood to mimic those made of

metal, and obtained better cures than the original inventor; and thus the bubble burst.

One of the most interesting of the trick practitioners of former days was Mesmer. He, again, lived in the eighteenth century and was also a local practitioner, so that quackery does not only exist outside the ranks of the orthodox. He took his M.D. at Vienna. In Vienna he was not accepted, but moving to Paris his reputation grew and he became the rage.

At first he was only misguided. When his influence grew, vanity obscured his honesty, and one reads of all the paraphernalia of the charlatan—spacious salons, stained-glass windows, coloured lights, fragrant fumes, velvet and soft music.

Let me quote\*: "In the middle of the principal salons was deposited an oval vessel, about four feet in its major diameter, and one foot in depth. This receptacle contained a number of wine bottles, filled with magnetized water, well corked, and disposed in order, with their necks outwards. The vessel was filled almost to the brim, and iron filings were thrown into it at intervals, to increase, it was said, the magnetic effect. An iron cover, called the *baquet*, perforated with many holes, completed the apparatus—a long movable rod of iron issuing from each aperture, for the patients to apply to the diseased parts of their bodies. The patients sat round the vessel, holding each other's hands, and pressing their knees together as closely as possible, in order to facilitate the circuit of the magnetic fluid.

"The assistant magnetizers then entered—stalwart and handsome young men—who were supposed to pour into the patient from their finger-tips a fresh supply of the magnetic fluid. They embraced the patients between the knees, rubbed them gently down the spine and along the course of the nerves, pressed gently on the bosoms of the females, while fixing them with a magnetic glance from their eyes in anticipation of the Ancient Mariner and the Wedding Guest in Coleridge's ballad." One wonders whether they would not have come under the ægis of the General Medical Council. One is almost permitted to say, "Who would not have been a neurologist in those days?"

It is really difficult to believe how Mesmer could have kept so long the possession of public attention. His methods attracted the Court and the Government, and so impressed were the Government that they offered him a pension of twenty thousand francs a year, and offered to make him a member of an order if he would communicate the discovery to physicians nominated by the King. He evaded the offer. They then appointed a Commission to inquire into his methods; the commissioners reported unfavourably, and Mesmer

\* *The Healing Art*, S. L. H. Davenport Adams.

disappeared with a sackful of savings which he spent to a large extent in this country.

I will now move a little nearer to our own times by dealing with the osteopath. The osteopath is the descendant of the bone-setter, and it is an interesting fact that Barker, who was the archbishop of the osteopaths, succeeded to the practice of Hutton, who was the great bone-setter of the Victorian era. It is important to know what these things stand for. Osteopathy ascribes maladies to misplacement of anatomical parts, and especially to faulty arrangements and alignment of the vertebrae.

The treatment consists of manipulation of the misplaced parts with a view to their correct replacement. It is done with vigour, and often accompanied by clicks, which provoke a strong and confident statement that the malady will immediately cease, and so sometimes it does. I have not heard of skiagrams being taken before and after treatment.

One may discern in these treatments: (a) physical examination and treatment of the body, and (b) the influence on the patient's mind. Sometimes there is a dexterous manipulation of the part affected, and in other instances there is only a ritual handling of the body, and this is made the means of exerting a forcible impression on the mind. There is nothing radically unsound in these methods. When they fail it is because a false diagnosis of the condition has been made. If the manipulation is harmless, there may remain a beneficial influence due to suggestion; where the case is one unsuitable for manipulation grave harm may result. It is quite true that there are certain gifts given to the hands which are inborn, not acquired—a dexterity without a reasoned basis, and therefore not teachable to others. Such is so-called "manipulative surgery." If it were practised within its proper ambit and applied only after skilled diagnosis and under skilled direction, how useful it would be! I come back once again with undeviating insistence to the maxim that diagnosis must precede treatment.

I now pass to the consideration of methods of treatment which depend on mental influences, and use but little manipulation or other physical modes of approach.

I will select Coué's teaching—and what may be conveniently comprised under the term "Faith-healing."

M. Coué's method seeks to take control of the patient's subconscious mind—the constant and rhythmical repetition of the phrase "*ça passe*," for the time so occupies the subconscious mind that the latter is impervious to the influence of the reason.

With periodic repetition of this exercise the impression remains, and the subconscious mind accepts and keeps the idea that this or that symptom has passed.

The merit of this method is that M. Coué trains the patient to help himself. But is that all? No, M. Coué's forceful, cheerful personality, his atmosphere of sincerity and confidence make a deep impression on his patients—he immediately secures followers who pass into disciples—and the assertion to his hearers that his personality counts but little deepens his influence, for is it not true that mental influences often reach their best when they are incidental rather than intentional—implicit rather than explicit? The Coué method is, in short, auto-suggestion reinforced by suggestion.

So far, so good. The method, applied to functional disorders, whether standing alone or as part of organic disease, is one of usefulness—and only disadvantageous because of its detachment from other treatment, and when its claims go beyond facts. But when its claims are extended to the curing of *developed* structural disease, then a doctrine is being propounded which is not only erroneous, but dangerous; and a similar false doctrine is found in the teaching of Christian Science and some forms of Faith-healing.

There is no evidence, for example, that a tumour disappears under psychical treatment, and such teaching is dangerous, because it leads patients to postpone physical treatment until too late.

"Render unto Cæsar the things that are Cæsar's, and unto God the things that are God's."

Faith-healing is so large and diffuse a topic that I will limit myself to healing by the influence of a personality. Here the healing depends on the attributes of the personality on the one hand and the reaction of the patient on the other. The attributes of the healer are in part inborn, though cultivation may do much to enhance them; whether they can be inspired from without, *i. e.* implanted by Divine gift, is a question outside our present inquiry. Our daily experience, whether in the wards or elsewhere, must lead us to conclude that the influence of mind is an integral part of healing.

You have only to practise for the space of one week to realize that the reaction of one mind upon another is an important factor in the treatment of ill people. To push it aside is not to solve what will be for you an increasingly important question, for remember this: that the complexity of life does not get less; it gets more. In the future you who have to treat disease will come up against an increasing number of illnesses which are characterized by physical and mental states that will need an understanding of the influence of mind. It may be that when we use it successfully, it is because we do so unconsciously. That is a criticism against mental healers—that they are people detached from physical healing.

I will give you two examples. A patient, after weeks of unconsciousness due to typhoid fever, gradually emerges, and for a fortnight remains on the threshold of consciousness.

We all know how painful and enfeebling that phase can be: dreams, terrors, cries, restlessness, insomnia—and narcotics and hypnotics gave but poor results. Then came on the scene by good fortune *one* nurse, who, by touch and voice, or shall I say through touch and voice, quelled the troubled spirit, gave sleep, and contributed in no small measure to recovery.

Another example: An aged lady, great in mind and character, had recurrent carcinoma of the breast and suffered agonies of pain in her arm. One day she said to me, "Would you mind if we let a healer try and help my arm," and she mentioned the best-known healer of that time. I assented, and offered to meet the healer in consultation. For several weeks that healer substantially reduced the pain and brought her peace. One day she said to me, "I feel the good Mr. X— can do me is over, and I would like his visits to cease." By that time the end was nearer, and morphia carried us through.

In both these instances we saw mind-healing at its best. Why? Because it was not dissociated from physical healing. When dissociated, mind-healing loses its sense of proportion, its pretensions grow and grow, the healer falls with dangerous facility into a dependence on the accidentals rather than the essentials of his art. He thus gets on to a basis of falsity rather than truth, and becomes as sounding brass and tinkling cymbals. There is no department of treatment which goes mad so easily as psycho-therapy.

The remedy for these dangers is to secure that all forms of treatment should be guided and co-ordinated by the doctor—but this supposes a wide comprehension on the part of the medical profession of what treatment includes and a readiness to secure the help of ancillary callings. Such comprehension is growing apace. I need only instance the midwife, the masseur, the electrician, and why not the manipulator and healer?—provided always one essential, *viz.* that *diagnosis and direction precede treatment*.

As regards mind treatment, there is danger of losing direction in the learning of medicine; on the one hand advances in pharmacology rightly give prominence to specific remedies like digitalis, insulin, emetine, quinine, etc., and on the other hand, there is a tendency to push the estimate and treatment of the mind factor into the ken and care of the psycho-therapist. Therein lies error. Body and mind cannot be thus separated either in diagnosis or treatment. In both functional and organic diseases there are the reactions

of mind and temperament, and we have to study, not only the material disease, but the complete fabric or make-up of this or that personal illness.

Moreover, structural disease may have a psychical as well as a physical beginning. Let me instance Graves's disease and certain forms of high blood-pressure. Inborn traits and reactions, impressionability, sensitiveness, over-conscientiousness reacting on some varieties of physical make-up will produce, say, increased secretion or vaso-constriction. Then develops what may be called physiological habit, and so gradually there evolves full-fledged structural disease.

This is emphasized the importance of the study of medicine by the student at the bedside. There he will study first the symptoms and signs of physical disease, and at the same time will be brought in contact with characters, temperaments and difficulties of patients' lives which go far to determine the form of their illnesses. In this way imaginative insight will gradually become one of the qualities of the student's mind.

The psychical factor in illness is likely to play a larger, not a smaller part in the future; the material resources of civilization have developed so rapidly that they have outstripped man's power of adaptation, and strains and conflicts will need more careful consideration. That is seen in the increase of illnesses due to "exhaustion" states, which illustrate that the best healing of the mind is that which is not obtrusive and still less exclusive, but rather accompanies a sound physical treatment. Absence of the latter and the ascribing of the illness to "neurasthenia" or erroneous habits of thought are apt to debase the patient. Even if true, the "sick" are not yet prepared for this: they cannot get away from the feeling that what is physical is real, and something they cannot help, whereas what is psychical is unreal and something they can help. This misconception is perhaps due to mistaken teaching about the doctrine of free will.

Let me illustrate: An educated lady, after an excessive spell of public work, became "exhausted" and was quite ill. On the physical side she had flatulence, irregular action of the bowels, passing of mucus and various abdominal discomforts, with at times distressing palpitation. On the psychical side sleep was disturbed, there were the restlessness of fatigue, loss of sense of proportion, a troubled mind and a harassed conscience. Exhaustion was the correct diagnosis, and on this occasion, knowing her intelligence, I explained this diagnosis, and based on the latter a plan of rest and simple treatment. To the latter she agreed, and went to the seaside under the care of a good doctor with a strong bias towards inoculation.

The patient became troubled, and could not justify to herself so long a treatment for mere exhaustion. She

confided in the doctor, and he suggested intestinal infection might be the cause of her illness. With my consent the faeces were examined. Needless to say the result was positive. The next day I received from the patient a grateful letter in which occurred this sentence: "Don't you think it is very satisfactory that we have discovered the real cause of my illness."

And so the faecal bacteriologist came into his own, and the patient had found a physical peg on which to hang her illness. We then hung the treatment on the same peg: these inoculations were continued for three months under conditions of rest, diversion and sea air, and complete recovery ensued.

Only a passing word on psycho-analysis. This should be limited to selected cases, and its practice to the few who are specially trained and possess the useful gifts of mind.

Psycho-analysis requires the clinician; it should never be crude and lay bare a patient's soul. Clumsy questioning, like clumsy surgery, can easily produce irreparable damage.

I plead therefore that we should take a large and comprehensive view of treatment—that physical and psychical healing, or, as it will some day be, physical and psychical education, shall not be divorced from each other, and that all forms of treatment should be co-ordinated and directed, though not necessarily executed, by the doctor, and based on sound and accurate diagnosis.

### ALCOHOLISM.

(Concluded from p. 74.)

*Habit.*—The habit of taking alcohol raises here another difficulty, and it is of advantage to consider the process of the formation of habit in order that this may be better understood.

The importance of habit-formation in the life of everybody is very great. It can be considered that without it no progress could be made during a man's lifetime, and civilization would never have been attained. The formation of a habit, that is, the formation of a subconscious direction of a certain series of processes in the central nervous system accompanied by a corresponding series of movements of the body, allows the ordinary activities of life to be carried on with the smallest interference by the conscious mind. It leaves the latter free to receive impressions, to correlate new experiences with established memories, and to develop ideas and projects which are the forerunners of progress, and, therefore, of mental development.

A simple example is that of walking, which is learnt by the child laboriously, with many halts and tumbles. The co-ordination of the idea of progress, with the

correct succession of patterns on the cells of the motor cortex of the brain for the necessary movements and with the mechanism of balance, requires practice and a constant repetition of the one process. Once this has been established, walking becomes a habit, so that progression becomes automatic and leaves the conscious mind free to act in other directions.

The conscious conception of an idea for the performance of some action liberates a certain amount of energy, probably electro-chemical in nature, in the brain-cells, and this should naturally be followed by a corresponding action of the muscles. Until the energy needed for the movements has been utilized, the particular system involved cannot return to a resting state nor allow recovery to take place by giving time for the potential energy to be restored.

The same process must occur when the movements are subconscious and automatic, and, therefore, it is just as disturbing to the body when a habit activity is checked as when some voluntary activity is prevented from attaining its object.

This can be observed in a child who is playing with some forbidden object. The succession of movements is prepared in advance, and the necessary energy is aroused before the successive movements can take place. If the object is suddenly taken away from the child he will be distressed, not only because the object that he looked upon as his own for the moment is taken away from him, but because the energy that has been prepared fails to be utilized. This occasions a restlessness which embarrasses the child, and he will often feel compelled to touch the object again as soon as he can find an opportunity for doing so without consequence, and sometimes when he knows that punishment will follow. The same effect will be noticed in the grown-up who is accustomed to leave some object that is in constant use in a certain place, and who finds that it has been removed elsewhere. Everyone knows the feeling of irritation that this produces.

This particular mechanism offers one of the chief difficulties that the alcoholic has to face at the beginning of treatment. It has become habitual for him to go to certain places, to order alcoholic stimulant and to drink it. At certain times of the day and in certain circumstances this activity is aroused subconsciously, apart altogether from any desire for alcohol. This obliges him to check continually an activity which has become subconscious, and it is liable to cause a restlessness and a physical distress which tends to increase his need for alcohol. He has been using alcohol for the purpose of covering over and diminishing similar motor activities during the time that he has been taking alcohol, and the first attempts to avoid taking it will,

therefore, end in a greater need for the drug than he had previously.

Realizing that this activity is generated in the motor cortex of the brain, it is necessary to assist the patient by giving him fairly large doses of depressants to the nervous system. Bromide is the most valuable of the drugs that can be used for this purpose.

*Treatment* (continued).—Treatment consists of five parts: The finding of the cause, the changing of the environment, the alteration of the old habit, the replacement of the alcohol by something that can take its place, and the use of suggestion, which method of treatment finds in these cases its most successful application.

Some idea of the kind of disturbance that has to be looked for is conveyed in the two cases that have been mentioned in the earlier part of this paper. It can be said generally that the patient who has once learnt that the ordinary troubles of life can be made to appear less disturbing by taking alcohol will take this easy means of avoiding any difficulty that arises. The fact that the patient has learnt to take alcohol for this purpose is, as a rule, accidental, and in similar circumstances all kinds of methods are used by mankind to achieve the same purpose. It is probable that in all such cases the patient is by temperament or by training less capable of dealing with the ordinary difficulties of life than is the case with his more fortunate brothers.

There is no real difference between the alcoholic and the man who wanders away in a fugue to escape a difficulty, or the man who has an hysterical fit when he is over-excited, or the housemaid who goes off to sleep whenever she is reproved by her mistress for a fault. In all such cases the more frequently this method of defence is indulged in, the more easily it occurs, and after the habit is well established smaller and smaller stimuli are required to put the defence mechanism into action. This is exactly parallel with the case of the alcoholic.

An American who was an habitual drunkard once told me that his drinking began when he was a student at West Point, where, at the age of 18, he was jilted by a girl with whom he fancied himself in love. He said, "I naturally got drunk for ten days." It appeared to him, and probably to his friends, that this was the correct thing to do in order to mark adequately the seriousness of the situation. Such a beginning had more effect than the simple conforming to custom: it meant that this man had learnt the value of excess in alcohol.

The taking of the history in such cases should involve a careful examination of the patient's upbringing, and whether or not the type of control that was developed in his childhood was sufficient for the needs of his everyday

life. It should also be seen whether his present method of life or environment offends very greatly against his upbringing and, therefore, against his social ideal. The history of the taking of alcohol, taken step by step and side by side with the conditions of his life when the habit was developing, will often give a clue to the cause. It is important that the patient should understand each step of the examination, and he should be given a clear understanding of the type of difficulty for which the physician is searching so that he may assist in the search.

The advantage of this method of approach to the patient is that he will begin to develop an interest in his own condition, a wish to recover, and a belief in his capacity to assist in his own cure. There is an advantage in treating the patient while he is going about his ordinary affairs. If recovery can be effected in the ordinary circumstances of the patient's life, then such a recovery can be looked upon as permanent. Once he has known all about his own condition, and has made his recovery, it is very rare for a patient to go back again to the misery that he endured when he was drinking heavily.

*Acute alcoholism.*—It is obvious that such an examination of the mind cannot be conducted when the patient is in a state of acute alcoholism, and it is in such a case advisable to place the patient in a nursing home, where he can be carefully helped over an acute attack and where the first stages of his treatment can be undertaken.

The management of the acute attack is generally a matter of treating symptoms. The chief of these are depression, sleeplessness, restlessness and acute delirium, and, after the attack is over, profound physical exhaustion. Drugs to be used are the bromides, luminal, apomorphine and hyoscine in this order, depending upon the severity of the symptoms. Apomorphine is particularly valuable, because it produces slight nausea, which takes away the craving for alcohol and usually induces a short sleep, which can be prolonged by giving luminal or medinal or some similar hypnotic about a quarter of an hour before the injection of morphine is given. Apomorphine should be given by an injection of from three to five minims of a 1 in 200 solution, and the patient should be in bed or resting comfortably before the injection is given, so that he shall be ready to go to sleep.

The patient should never be deprived of alcohol abruptly. It must be discontinued gradually, and a large amount of fluids in other forms must be given. The spirit can profitably be given in ginger ale, and, after the alcohol is discontinued, the patient can continue with ginger ale as a beverage. Besides this,

large quantities of lemon drink, orangeade and Vichy water should be given.

In a very acute stage, with delirium, the patient must be watched by nurses continually, and preferably there should be two nurses present, because the patients in this stage are often extremely violent and may be very dangerous to themselves and to others.

As recovery takes place care must be taken to avoid physical collapse. Apart from these precautions, treatment is symptomatic and offers no real difficulty.

*Environment.*—It has been stated above that the causes of alcoholism in the type of case that is being considered is some discrepancy between the environment, by which is meant all the conditions in which the patient lives, and his social ideal, which is the result of training. When this is discovered and made clear to the patient, the next step is to consider in what manner the difficulty may be dealt with.

The simplest possible method is to change the environment, and it may well be that this must be done at all costs if the patient is to recover. It frequently happens, however, that the difficulty is in either the domestic or business life of the patient, in which case a change of the environment would mean a complete upheaval of his ordinary life. Such a change must be avoided if it is in any way possible, and usually some alternative to this can be found.

If the difficulty arises as the result of some error in the patient's upbringing, it is possible to re-educate the patient by going over his early life gradually, so that in the end he comes to have a new outlook, realizing the part played by his upbringing in unfitting him for his ordinary life. This is to change the patient's whole character, and not only is it a very slow and difficult process, but it is undesirable from many points of view.

The easier method is to attempt to modify in some way the patient's reactions to the circumstances that surround him, and to try and replace an intolerant attitude by a wider tolerance. Where the patient is unfitted temperamentally for the kind of life he is leading, it is better that he should change it, if this is to lead to recovery, than that he should persist with it and remain a drunkard, bringing unhappiness upon himself and upon all those who are in any way connected with him.

*The use of bromides.*—Alcohol can often be replaced by bromide for the reasons given earlier in this paper—that it is often a motor activity of the body and a restlessness that alcohol can cure that is turning the patient into a chronic alcoholic. The best preparation is probably ammonium bromide, which produces a sedative effect without causing depression or any other form of ill-health. It can be taken over long periods, and when

the patient is feeling disturbed he will learn to take a course of it and so protect himself against the physical damage that alcohol causes.

*The social life.*—Changing the social life in order that the patient may avoid the necessity for taking alcohol with his friends must be left to the patient himself, for as recovery proceeds complete abstinence is essential. It will usually be found in any decent society that when a man's friends realize that he is avoiding alcohol for the sake of his health they will assist him in his abstinence rather than encourage him to drink. If his companions are such as to disregard his wishes and encourage him to drink, the patient will very soon find for himself that he is better off without such friends.

*Suggestion.*—The idea of suggestion treatment is to produce a state of affairs that ignores the symptom, and makes the patient live as if the symptoms did not exist by placing suggestions in his mind. Where there is a true mental strain this is only a temporary measure, because eventually the suggestion treatment must be stopped, and its temporary effect diminish, in which case the patient will return to his habits and the treatment will fail. But taken in conjunction with the treatment outlined above, suggestion treatment is of the greatest value, because it helps the patient to tide over a difficult period while his re-education is being effected.

The patient need not be hypnotized. Suggestions can be given in a state of rest and relaxation, which can be quite easily produced without any of the methods of producing hypnotism, such as eye-fixation, and without any tests to demonstrate the control of the patient by the hypnotist, which are so irksome to the patient and which produce a feeling of self-depreciation. When the patient is relaxed and is used to the physician and to the tone of his voice, and when he has listened once or twice to the repetition of the suggestions, his thoughts will wander away to other subjects, leaving his mind open to accept the suggestions. These should be simple and straightforward, and should be directed towards producing a distaste for alcohol, a wish to abstain from it, and a wish to avoid those circumstances in which he previously drank too much.

Occasionally suggestions can be given for the production of nausea or vomiting when alcohol is taken. For these to be effective the patient must be well under the control of the suggestionist, but if the effect of protecting the patient against alcoholism can be attained without this control, it is better for the patient and his re-education need not be so prolonged.

*Re-education.*—There is no particular art in the re-education process. Its need depends upon the condition in which the patient is found. If very much social degradation has occurred, then the re-education

is of necessity longer and more difficult. The patient must be able to get a belief in himself, and to feel that he can face difficulties without resorting to alcohol. His mind must be adjusted to those conditions of his life which previously caused him to drink, or if this is not possible, his way of living must be changed in order that these strains may be avoided. Each step that the patient takes towards recovery will increase his belief in himself, so that as progress occurs it will be more and more rapid.

These cases of alcoholism respond well to treatment when any response is possible, and no cases should be looked upon as hopeless, no matter how long the patient has been drinking. This is exemplified by the case of a man who began drinking at the age of 21 and was cured at the age of 65.

The sufferers from alcoholism require patience and understanding, and a greater sympathy than they usually obtain, and if they are treated along the lines indicated in this paper, it will be found that the recoveries greatly outnumber the failures.

ERNEST SNOWDEN.

## TWO UNUSUAL CASES OF PERFORATED DUODENAL ULCER.

CASES of perforated gastric or duodenal ulcers are, I believe, rarely seen in private practice, but they are among the commonest of all forms of acute abdominal emergencies met with in hospital practice. In two years, 1924-1925, perforated gastric and duodenal ulcers were placed third in order of frequency of acute abdominal conditions at the Leeds General Infirmary (1). During these same two years they were placed second in order of frequency at St. Bartholomew's Hospital, and a comparison of the two tables of statistics is interesting:

### At Leeds General Infirmary.

	Cases.	Deaths.	Percentage.
1st. Acute appendicitis . . . . .	1080	58	5.7%
2nd. Strangulated hernia of all types . . . . .	190	43	22.6%
3rd. Perforated gastric or duodenal ulcers . . . . .	150	34	22.6%
4th. Acute obstructions . . . . .	139	55	40%

### At St. Bartholomew's Hospital.

	Cases.	Deaths.	Percentage.
1st. Acute appendicitis . . . . .	669	20	2.9%
2nd. Perforated gastric or duodenal ulcers . . . . .	97	15	15.4%
3rd. Strangulated hernia of all types . . . . .	69	6	8.6%
4th. Acute obstructions . . . . .	54	14	25.9%

The mortality, not only of perforated gastric and duodenal ulcers but also of all other acute abdominal conditions, is due almost entirely to the delay between the onset of the acute symptoms and the time of operation. Out of the 15 cases in our series of perforated ulcers which died, no fewer than 11 were operated upon six hours or more after perforation.

Formerly the mortality was very high in perforated ulcers; this was due to the fact that these cases were not recognized as such in their early stages, and very frequently were not operated upon until general peritonitis had appeared. Since then the symptoms and signs and appropriate treatment have been clearly defined and emphasized. The cases are, as a rule, recognized in their early stages and operation is performed at the earliest possible moment, with a corresponding decrease in the death-rate. This is illustrated by a comparison of the following statistics with those quoted above:

In 1899, of 29 cases recorded by Pagenstecher (2), the mortality was nearly 86%.

From 1899-1902, 42 cases were operated upon at the London Hospital with a mortality of 80%; while from 1900-1919, 218 cases were operated upon at the same hospital with a mortality of 40%. In 1910-1911, 50 cases were operated upon at St. Bartholomew's Hospital with a mortality of 42%. It must be very unusual in these days to see cases of perforated ulcer operated upon more than 48 hours after perforation, and still more remarkable to see them recover.

Two such cases were admitted to St. Bartholomew's Hospital within a few weeks of each other; one of them had a duodenal ulcer which perforated sixty-six hours before admission, and the other also a duodenal ulcer, which perforated four days before admission, and both recovered.

In addition, their histories, symptoms and physical signs and their appearances at operation afforded such a contrast to each other in the manifestations of one and the same disease, that the publication of their notes may be instructive as well as interesting.

CASE 1.—A man, æt. 50, was admitted to St. Bartholomew's Hospital on August 17th, 1927, complaining of abdominal pain.

*History.*—He was in his usual health until August 13th, 1927, when he felt a pain in the right hypochondrium; it was not severe, and its onset was gradual. During that night and the next day the pain became much worse and the patient rolled about in agony. On August 15th and 16th his condition remained the same, the pain being alleviated by repeated injections of morphia. During this time there had been nausea, but no vomiting, and no melæna was noticed. The

patient had never been ill previously, and there was no history of indigestion or abdominal pain. (This is a very unusual feature, and was one of the reasons which led to an incorrect diagnosis being made.)

*Condition on examination.*—He looked ill and anxious; perspiring, and rolling from side to side in agony. Temperature 98°, pulse 78, respirations 20.

*Eyes:* Pupils reacted normally; no conjunctival icterus.

*Chest:* Slight bronchitis.

*Abdomen:* Was rigid in the upper half, more so on the right side than left. Tenderness was most marked over the tip of the ninth right costal cartilage. The rest of the abdomen was flaccid, moved well on respiration and was not tender. No shifting dullness was detected, and the liver dullness was normal.

*Reflexes:* Knee-jerks equal and brisk.

*Urine:* Trace of albumen; bile-pigments present.

*Diagnosis.*—Acute cholecystitis. A perforated duodenal ulcer was excluded on account of the absence of any history of indigestion previously, the localization of the rigidity and tenderness, and the fact that he rolled about instead of lying still.

*Operation.*—On August 18th, 1927, five days after the onset of the symptoms, an operation was performed by Mr. Dunhill. A general anæsthetic was given by Mr. Hewer. On opening the peritoneal cavity the gall-bladder was found to be normal. Adhesions between the first part of the duodenum and the liver were separated and bile-stained fluid and pus appeared; this was aspirated, and was found to be tracking upwards to the right subdiaphragmatic region. A perforated duodenal ulcer was found when the adhesions had been separated, and it was then closed by interrupted sutures. There was a localized peritonitis and a track of pus led to the right subphrenic region; drainage tubes were inserted down to this region and to the duodenum, and the abdomen was then closed.

*After-history.*—A post-operative bronchitis, leading on to broncho-pneumonia, occurred, from which the patient nearly died. On the ninth day following the operation a secondary hæmorrhage occurred from a branch of the right superior epigastric artery, and the wound burst open, the stitches cutting through the skin owing to the degree of sepsis. This necessitated another operation and a blood-transfusion, a second post-operative bronchitis occurring. There were no further complications, and the patient was discharged on October 5th, 1927.

CASE 2.—A man, æt. 57, was admitted to St. Bartholomew's Hospital on October 10th, 1927, complaining of severe abdominal pain.

*History.*—During the previous year he had had attacks

of epigastric pain, coming on 1½ to 2 hours after food, and lasting until the next meal, which then relieved it. There had been nausea, but no recent vomiting, and no melæna noticed. On October 8th, 1927, the patient was awakened at 2 a.m. by agonizing abdominal pain, most marked in the epigastrium, and which doubled him up. Opiates were administered then, and periodically, for the next forty-eight hours. He became rapidly worse, and arrived at St. Bartholomew's Hospital sixty-six hours after the onset of the acute abdominal pain (? symptoms).

*Condition on examination.*—The patient was extremely ill, lying quite still on his back with knees drawn up, in great pain. Temperature 97°, pulse 128, respirations 24.

*Eyes:* Pupils reacted normally.

*Mouth:* Pyorrhœa and much oral sepsis.

*Chest:* Lungs, emphysema and marked chronic bronchitis, *rales* being heard all over the chest. Heart-sounds distant, otherwise nothing abnormal discovered.

*Abdomen:* Distended in the lower half and absolutely rigid in the upper half; generalized tenderness, most marked in the epigastrium to the right of the mid-line. Free fluid was present, and the liver dullness was absent.

*Reflexes:* Knee-jerks equal and brisk.

*Diagnosis.*—Perforated duodenal ulcer.

*Operation.*—Sixty-six hours after the onset of acute abdominal pain. The operation was performed by Mr. Dunhill through a mid-line incision above the umbilicus, the anæsthesia being nitrous oxide gas, oxygen and chloroform, administered by Mr. Roxburgh. General peritonitis was present with free fluid, and a perforated duodenal ulcer was found on the anterior surface of the first part of the duodenum. The perforation was closed, and as much as possible of the free fluid was aspirated. The abdomen was then closed with drainage-tubes inserted through the original incision and also supra-pubically.

*After-history.*—The patient recovered slowly until the third day, when the pulse became irregular in force and frequency; there was incontinence of fæces, and occasional delirium. His condition varied slightly from day to day during the next fortnight, but after that he steadily improved and was discharged on November 2nd, 1927.

He was seen again on February 13th, 1928, and was in the best of health, had gained in weight and he had had no recurrence of indigestion.

The first case was atypical in almost every respect. There was no previous indigestion of the type which Moynihan (3) has shown to be so characteristic of the disease, and it was an acute ulcer that perforated. Its

onset was insidious, and on arrival at hospital he was rolling about in agony. These factors, with the localization of the inflammatory process, and aided perhaps by the morphia, were responsible for the masking of the true state of affairs. The second case was classical—in the previous history of indigestion, in the manner of onset of the perforation which is characterized by such awful agony—so awful that one patient told me that he would have shot himself if he had had a revolver—and in the physical signs. His recovery was even more surprising than in the other case because he had a general peritonitis of over two days' duration.

These patients were under the care of the Surgical Professorial Unit, to whom I am indebted for permission to publish these notes.

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- (2) SHERREN, J.—*Choyce's System of Surgery*, 1923, vol. ii, pp. 382-383.
- (3) MOYNIHAN, SIR BERKELEY.—*British Medical Journal*, February 10th, 1923, p. 222.

L. V. PEARSON.

#### AMOR.



UA Via per varios cursum tenet Aurea muros,  
Est domus. Huc fessum corpus amore venit.  
Hic medicus. Cives adeunt, vulvaeque pungent.

Mulcentur, teneri testiculique dolor.  
"Te gonococcus habet," dicit "Tua brachia pungent."  
"Sunt tibi verrucae." "Tu treponema foves."  
Non noscit pueros Lalage Damonve puellas;  
Non Venus, at sedes fetida causa mali.  
Jam sani "Pyelitis erat," vel, "Anæmia" dicunt.  
Sic rosa mutato nomine dulcis olet. ANON.

#### DEBATING SOCIETY.

"That the censorship of plays in this country should be abolished." This was the motion before the house at a meeting of the St. Bartholomew's Hospital Debating Society held in the Abernethian Room on February 7th, 1928, when the chair was taken by Sir Thomas Horder, Bart.

Mr. J. W. O. FREEMAN, in proposing the motion, said that the censorship was an unwarrantable restriction on the liberty of the British people. In recreation and sport we were unfettered, but in drama we were hemmed in on every side. This restriction had an adverse effect on dramatic art. No dramatist who was worried by a Censor could be expected to produce his best work. Even professors who attempted to use the stage for educational purposes were not exempt from this ban.

The worst aspect of the Censorship, however, was its futility. Not only were plays banned by the Censor produced here in London, but those which did scrape past the Censor received a great free advertisement from the newspapers, which attracted to the play crowds of young people who would not otherwise have afforded a theatre.

The Censor could only ban very immoral plays. These would do no harm if they were produced. They would shock and so prevent

indulgence in immorality, but the plays that just, and only just, passed the Censor made immorality interesting, fascinating and enticing to the young people.

Mr. D. K. JARDINE, replying to the motion, divided the public into two classes—the educated, who had a strong moral fibre, and the uneducated, who might be swayed by immoral plays. The former class were capable of acting these plays privately, or of reading them and thereby understanding and appreciating their artistic merit. The latter class, however, had to be protected, and it was for these people that there was a Censor.

If an immoral play were put on the stage at a public theatre, the uneducated would think that the educated approved of its vice, and they would soon become corrupt. There was no difference between an immoral play produced for its immorality and an immoral play produced by a professor, or, for that matter, by the Lord Chamberlain himself—they all had the same effect on the uneducated.

In conclusion the House was asked to consider whether art was justified at all costs. True genius could not be fostered, but would make itself evident in other ways. No painter would represent on canvas the ugliest things he could find in life, yet this was what one found on the stage. No such plays could be really artistic, and they could not be justified on these grounds.

Mr. A. HUNT-COOKER dwelt at some length on the restrictions on liberty which the Censor imposed both on the individual and on the playwright. He also thought that the uneducated had as much right as the educated to choose their own type of entertainment. To compare what is with what might be one had only to consider plays which had stood the test of time. Much of Shakespeare's work would not pass the Censor.

Mr. I. W. MATHESON, in seconding the opposition, said that although he was not a student of Shakespeare, there was one of his plays which he had studied very carefully for an examination. In "Macbeth" there was nothing that could make even the oldest of old maids blush, and in any case there was evidence to show that many plays of Shakespeare had been tampered with, and immoral bits inserted.

Mr. I. PREISEKEL, speaking from the House, considered that immorality on the stage was but a manifestation of a general decline in art. It was illegal to publish indecent pictures and books, and plays should be treated similarly. The main objection to the Censorship was its futility. Surely this was a reason for tightening up the Censorship, not abolishing it. If a ligature did not control haemorrhage a surgeon would put on a tighter one, not remove the poor one.

Mr. P. ROBINSON contended that a theatre was not a public place, but the private property of the owners, and just as the "Englishman's home was his castle," the theatre should not be governed by outside bodies. The law against public indecency was sufficient to protect the public from the production of indecent plays.

The play "White Cargo" was banned, although it was a true picture of life on the West Coast of Africa. It was better for people to be warned of such conditions by means of a play than that they should unexpectedly meet them in reality.

Sir THOMAS HORNER thought that too much attention had been paid by previous speakers to one function of the Censor, namely, that of protecting the public from indecent exhibitions. He thought that just as important were the functions of looking after people's susceptibilities, concerning their religious beliefs, and the question of *lèse majesté*. One could well imagine the type of cheap wit levelled at the Monarch which some unscrupulous producer might introduce on to the stage. Such things were obviously undesirable. I here could be no doubt that the theatre was a public place and should be ruled accordingly. Although a broad-minded man, he often experienced difficulty in explaining to his daughters what was meant by certain passages in plays.

In conclusion Sir THOMAS said he regarded the Censorship as a mild brake which was essential for the progress of civilization, and for the standard of morality on the stage.

Mr. A. SUGDEN said that a State had no right to question the integrity of its genius. The Censor resents criticism of the Church and State, but freedom of speech must be absolute, and a man able to say what he likes, as he likes, so long as it is true and does more good than harm. Should this point be uncertain the writer was the most competent judge.

Dr. E. R. COLLINAN effectively dealt with many of the arguments brought forward by the opposition in a speech which made an admirable summing up to the debate.

On a division being taken the motion was lost by 25 votes to 12, but the number of non-voters was very large.

## CORRESPONDENCE.

### "THE TRUSTWORTHINESS OF THE BIBLE."

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

DEAR SIR,—We have the assurance of your correspondent, Mr. Guinness, that the purpose of his letter in last month's JOURNAL on the above subject was to draw your readers' attention to the evidences of Christianity. *In vino* (and, I doubt not, in malt liquors also) *veritas*. One's first conclusion, therefore—that the letter was an ingenious, if not quite ingenious, advertisement of Dr. Pierson's book—is clearly untenable.

But, Sir, will you not draw your Manager's attention to the commercial possibilities of advertisements on these lines? Your correspondent's views are not universally accepted, and I cannot but think that volleys of quotations from the opposing camp in alternate months, though irksome to your readers, might at a fixed price prove financially profitable. Good wine needs no Bush, but commodities less obviously seductive may have some use for Hedges—as a recent libel case has shown.

Yours faithfully,

St. Bartholomew's Hospital, E.C. 1; M. MALLECHO.  
February 16th, 1928.

### "THE TRUSTWORTHINESS OF THE BIBLE."

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

DEAR SIR,—In this, the second letter of our series, the Christian Union would like to bring before your readers the great fact of the scientific accuracy of the Bible.

Yours very sincerely,

St. Bartholomew's Hospital, H. W. GUINNESS,  
London, E.C. 1; President.  
February 18th, 1928.

### THE BIBLE AND SCIENCE.

"The Bible, if God's Book, must have some relation, however indirect, to truth at large. The God of all truth cannot, in any of His utterances, contradict Himself. His Kingdom cannot stand and be divided against itself. Manifestly His works and His word must, in all essentials, agree. Hence the question as to the attitude of the Bible towards science cannot be avoided."

"The All-knowing God cannot be supposed to betray ignorance on any subject, nor the God of all truth to lead Himself to falsehood. Therefore on whatever theme the Omniscient One speaks, even incidentally and casually, He must be at home. God, the only Infallible Scientist, cannot be supposed to make mis-statements, or exhibit ignorance. This book claims to be Divine." If it is so, then it must also be scientifically accurate whenever it touches on this theme. Is it? Let the unbiased mind search and see.

### COMPARATIVE ANATOMY.

"This science is only about one hundred years old. Cuvier, about the beginning of the nineteenth century, lifted what had hitherto been a mass of unconnected details to the dignity of a science. He compared the various forms of animal life, observing and recording points of similarity and dissimilarity; and so arranging facts according to a scientific classification. Comparative anatomy shows an order in the animal creation, from the lowest forms to the highest, rather than reversely, the question of rank among vertebrate animals being determined by the proportion of brain to the spinal cord. In fish it is 2 to 1; in reptiles, 2½ to 1; in birds, 3 to 1; in mammals, 4 to 1; then in man it takes a leap, and the proportion of brain to the spinal cord is 33 to 1, which raises man far above any other animal."

"Common sense and observation might have shown Moses that man is far above mammals as a class, and the mammals higher than most fishes and birds, but no common sense or ordinary observation would have shown that the fish belongs below the reptile, or the reptile below the bird. Yet thousands of years before comparative anatomy took rank among the sciences, Moses followed the

correct order of classification in this story of creation. A candid and rational scientist looking at that first chapter of Genesis must ask how any unaided human mind could have guided the hand that wrote those words."

### GEOLOGY.

"So far as it may claim to have settled anything, geology outlines the story of creation somewhat thus:

"First, a state of chaos or general confusion, the solid, liquid and fluid elements being mixed somewhat as they are in a great conflagration.

"Secondly, that there was light, chemical or cosmic in character, which pervaded this general chaos or confusion.

"Thirdly, that condensation took place between the steaming vapours above and below, those below forming rain and water, those above forming clouds, and occupying what is called the firmament. There came to be thus an 'expanse' of atmosphere between the waters of the clouds and the waters of the sea.

"Fourthly, that out of this great abyss of waters the dry land appeared as the waters subsided.

"Fifthly, that upon this continent thus arising above the waters, vegetation began to appear, and took three forms—plant, herb and tree, or the grasses, the plants and the trees.

"Sixthly, the animal life, beginning with what are known as the 'protozoa' or first forms of life, which developed out of the ooze of the ocean bed; animal life ascending through its different grades until—

"Seventhly, man comes on the scene as the consummate climax and crown of God's creative work."

"Chaos, chemical light, expanse of atmosphere, appearance of land, vegetation in three forms, animal life, from protozoa to the highest vertebrata, and, finally, man—exactly Moses' order in the first chapter of Genesis! First chaos; then God says, 'Let light be,' and light was; then an expanse of atmosphere, the firmament (Hebrew 'Räkyä'—an expanse); then the continent, the dry land; vegetation in three forms; and, then, life—the waters brought forth life; then, bye and bye, higher animals, and at the end of the mammalia, man himself.

"Nothing was known about geology when Moses wrote, nor for thousands of years after. Who was it that guided him in this description of creation, to give thus accurately what the most modern of sciences affirms was the original order? There is nothing like this in ancient literature. Whenever any of the ancient writers touched the science of creation absurd blunders were made. Even Plato thought the earth to be an intelligent being, and earthquakes were supposed to be such motions of the earth as a huge animal would make if writhing in pain.

"Thus, those who search this Book reverently, find here and there suggestions from God to make them confident of His authorship of these mysterious pages."

(See Dr. A. T. Pierson's book, *God's Timing Oracles*.)

### TIERS AT POST-MORTEMS.

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

SIR,—The post-mortem demonstrations are important for the medical student of this Hospital, and every facility should be made that he may benefit by them.

At about 1.30 in the afternoon the rooms can offer to the expectant learner the view of one or two clusters of human beings, from the centre of which a faint murmur indicates that the Great are casting their pearls of wisdom. Only those who dare risk the defilement of their clothing by being crushed against the exhibits, or who are gifted with stature exceeding that of their fellows, can see or hear what is going on.

As a representative of those who possess neither "push" nor abnormal height, and who wish to add to their own observations the valuable addenda supplied by those of greater experience, may I suggest the erection of some system of tiers to deal with the congestion in the post-mortem room, whereby it may be transformed from the conglomeration of a series of motor cycle accidents into a place where one may acquire knowledge in a manner as dignified as the science which embraces it?

Yours faithfully,

ZACCHÆUS.

### ROUND THE FOUNTAIN: A TRIBUTE.

To the Editors, 'Round the Fountain.'

DEAR SIRS,—Anything about Bart's interests me always, and the booklet *Round the Fountain* which you have so kindly sent to me, with all its traditional and amusing lore of life in the Hospital, has given me a most pleasant hour. Please give my warm greetings to all my many friends, and permit me as a "Perpetual Student" of Bart's to sign myself,

Very cordially yours,

HARVEY CUSHING.

Peter Bent Brigham Hospital,  
721, Huntington Avenue,  
Boston 17, Mass.;

January 18th, 1928;

### MEDICAL ETHICS.

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

SIR,—May I mention a point of medical ethics which I think it is desirable to ventilate.

The case is this: A ritual general practitioner was consulted by a wealthy patient in his practice in regard to a broken finger. The finger was set and X-ray pictures were taken. A few days later the local doctor received a letter from a well-known orthopaedist in London asking him for the pictures of the fracture, saying that he was treating the fracture. This seems to at once reduce the orthopaedist from the position of consultant to one of general practitioner, and therefore only entitled to G.P. fees.

Besides being rude, the orthopaedist appears to have behaved in an entirely unethical manner.

I should like to hear the opinions of your readers on this matter.

Yours faithfully,

R. MURRAY BARROW.

Long Sutton, Wisbech;  
February 12th, 1928.

## STUDENTS' UNION.

### RUGBY FOOTBALL.

ST. BARTHOLOMEW'S HOSPITAL v. GUY'S HOSPITAL.

Semi-final Round of Inter-Hospital Challenge Cup.

February 23rd, 1928. Won by 5 points to 3. This, the most important match of the season, was played on a dull but dry day, with the ground in good condition, although a little on the soft side. Guy's had the misfortune to have to find a substitute for T. Garland, whose value to them as a match-winning player is well known, but they fielded a team which carried the money of all but a few of the most optimistic of our supporters.

The first half was typical of cup-tie rugby—an even game with a vast amount of play that was keen and hard rather than brilliant. From the start it was obvious that the two teams were evenly matched. For the first five minutes Guy's looked the more dangerous and a break-away by Spence almost led to a try against us, but then the game swung back in our favour. It was at the end of ten minutes that Guinness, after a good run in the centre, kicked out to the wing, where Grace gathered the ball cleverly, hauled off his opposing wing, and running strongly, outdistanced P. D. B. Spence, to score wing, and running strongly, outdistanced P. D. B. Spence, to score about ten yards in from the touch-line. It was an excellent try and merited the enthusiasm it aroused, which was deservedly renewed when Gaisford converted with a perfect kick.

There was no more scoring this half, and there was little to choose between the teams. The Guy's three quarters were rather more finished and snappier than some of ours, but this was more than negated by the good work of our forwards in the loose and the keenness of our back's tackling.

The second half started badly. From a charged-down kick Guy's took the ball into our twenty-five and kept it there, making continual efforts to score, which were finally successful at the end of five minutes, when Robinson just got over near the flag. Luckily Durr did not live up to his reputation as a kick, and we still led by two points.

For the whole of the remainder of the game we seemed to hold the advantage. Long before Guy's team was depleted by the unfortunate occurrence of two casualties it was seen that we were holding them territorially, and the frequency with which their centres were prone to kick told its own story of the effect of the pressure our men were keeping up. There was no further scoring. For a long five minutes we pinned them within ten yards of their line, but repeated attempts to get across just failed and a penalty kick drove us back, and then we had to be content with keeping them safely out of our territory.

We most sincerely regret the fact that Guy's lost two of their men through injury, but we feel it would be unfair to our team to suggest that the game was not won before either accident occurred.

Of the forwards, whose tactics in the loose played so great a part, we would mention R. N. Williams, whose leadership and example were excellent, R. H. Bettington, who showed that he had lost none of his skill by his invaluable work, especially in the line-out, and C. R. Jenkins, whose tackling so often pulled up dangerous-looking attacking movements.

The backs, too, played up to their best form. W. F. Galsford, after a shaky start, quite outplayed his opposite number. A. H. Grace did many good things apart from his winning try, while the defence of the centres saved us during many anxious moments. Last of all we mention the find of the season, J. T. C. Taylor, whose first season it is at scrum-half. Watching the game it seemed amazing how often it was just where he was wanted; his quick touch-finding and more than all his most effective ankle tackling proved his worth time after time. We should like to congratulate the whole team upon the result of one of the most exciting matches we have seen, and one in which the supposedly weaker team so far belied their fame that none could call them merely lucky to win—our opponents played below form simply because they were allowed to do no better, and we can only end by begging the team to show us as good a game with, we hope, as successful a result in the final. E. S. V.

#### HOCKEY.

ST. BARTHOLOMEW'S HOSPITAL v. CHRIST CHURCH, OXFORD.

February 4th. Winchmore Hill was in appalling condition for our match v. Christ Church: one part of the ground was a regular Slough of Despond; this was due, so Bell told us, to a broken drain, perhaps the result of his vigorous rolling. As neither team had played for a fortnight they determined to brave the mud and wet, and get some exercise whatever the conditions.

Christ Church won the toss and decided to play downhill. Bart's pressed the visitors' goal, but shooting soon became difficult owing to the slippery nature of the ground. Christ Church now began to adapt themselves better to the conditions; they adopted the hard hitting, forward passing game, and beat our defence with several well-combined rushes. At half-time they were leading 2-0.

Playing downhill, Bart's played up more strongly in the second half; from a scramble in the circle Francis scored our first goal. We continued to press, but found the Oxford keeper in fine form and very difficult to beat. Play continued very evenly for the rest of the second half; both sides scored one goal. The standard of play was quite good considering the nature of the ground. When the whistle blew Christ Church were leading 3-2.

Williams played a good game on the right wing, Wright and McCay broke up many attacks and hit hard and cleanly. The two wing half-backs were inclined to get too far up the field and let the opposing wing men right away.

Team: R. W. Windle (goal); F. H. McCay, P. M. Wright (backs); J. H. Attwood, W. F. Church, V. C. Snell (halves); E. J. Neill, J. W. C. Symonds, K. W. D. Hartley, R. H. Francis, A. G. Williams (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. MILL HILL SCHOOL.

February 8th. Mill Hill reported the ground to be in bad condition, but compared with Winchmore Hill last Saturday it was quite good, although very bumpy. Mill Hill won the match by 5 goals to 3, but the game was more evenly contested than the score would suggest. There was little to choose between the two teams; The Mill Hill goal showed fine judgment in running out and kicking, and saved many a hard shot. Hodgkinson, who was taking Windle's place in goal, had rather an off day; he should learn to come out quicker—hesitating is fatal. At half-time the score was 3-1 in favour of Mill Hill, but Bart's played up strongly in the second half and Hartley added two more goals, one of them being from a good

centre from Neill. As play went on Mill Hill, encouraged by the cheers from the touch-line, began to test our defence more severely; twice they broke through and scored, the final score being 5-3.

Hartley and Williams showed good form for the forwards. Hartley scored all three goals and Williams made many good runs down the wing. Fordham played a fine game at left half, intercepting with great judgment. His wing man found him difficult to pass. Snell put up a very creditable performance at right half, where he was playing in the place of John Attwood.

Team: H. L. Hodgkinson (goal); F. H. McCay, P. M. Wright (backs); V. C. Snell, W. F. Church, M. S. M. Fordham (halves); E. J. Neill, J. W. C. Symonds, K. W. D. Hartley, R. H. Francis, A. G. Williams (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. R.M.C., CAMBERLEY.

February 11th. The day was fine and the ground in beautiful condition for our match v. Sandhurst to Camberley. What a contrast to the wet and muddy conditions at which we are becoming so accustomed! The team cannot hope to really improve until grounds, especially our own, get into a fit state again. Playing with a strong wind behind them, Bart's found they were holding Sandhurst quite easily; this was somewhat surprising, as they are quite the strongest team we play. The forwards pressed the Sandhurst goal continually, being well supported by the half-backs. Williams frequently got away on the left wing and sent across good centres. Neill received some well-placed passes from Attwood, but was inclined to leave his centres too late. Bart's kept up a strong attack the whole of the first half, but owing to weak shooting and lack of following up they failed to score. The defence held the Sandhurst attack and fed their forwards well. From play in our "25" the ball accidentally went behind off Attwood; from the corner hit the inside left scored Sandhurst's first goal.

At the commencement of the second half Bart's again pressed, but soon a great change came over the game. Sandhurst, from playing a defensive game, began to attack strongly. The inside forwards, combining well with the outside men, broke through our defence on several occasions. Three times Leech, the Irish international inside-left, received a pass from his inside men, and each time he scored with shots that gave Windle no chance. Our forwards were often being let away with good passes from the half-backs, but their thrust and combination were poor and they never got beyond the strong pair of Sandhurst backs. The R.M.C. finally won 5-0, Leech being responsible for 4. The result was rather disappointing, as on the run of play we should have done much better. Williams and Francis were the best of the forwards. The half-backs and backs played a very fine game except towards the finish, when they rather went to pieces, largely through lack of encouragement.

Team: R. W. Windle (goal); F. H. McCay, P. M. Wright (backs); J. H. Attwood, W. F. Church, M. S. M. Fordham (halves); E. J. Neill, J. W. C. Symonds, K. W. D. Hartley, R. H. Francis, A. G. Williams (forwards).

#### SWIMMING CLUB.

The winter is rapidly drawing to a close, and in a comparatively short while regular swimming will be in progress. It is most unfortunate that owing to the diversity of the work engaged in by the various members of the Club, it has been found impossible this winter to fix a regular weekly practice which could be attended by a sufficient number to make it worth while. It is sincerely hoped, however, that all members, even if they have not kept in training during the winter, will commence training now for the coming season. With regard to this, we should like to draw attention to the well-known fact that the sort of physical fitness required for swimming is not the same as that required for any other sport—it is of an even higher standard, and can only be reached by swimming itself. In several matches last year the superiority of our training over that of our opponents was marked, but in a greater number our inferiority was even more marked; it should be the aim of each member to ensure that in this respect at least we are better than the others.

To those of our new (and old) members who were hoping to learn polo this winter, we extend the advice—come and watch the matches; not only will you learn something about the game, but you will also be lending the team some welcome encouragement from the "touch-line."

One final exhortation. All men interested in swimming, and who have not yet given in their names, are earnestly requested to get in touch with the captain (F. A. Edwards) or the Hon. Secretary (J. F. Fisher) at once.

#### REVIEWS.

BACTERIAL VACCINES. By Prof. DUDGEON, C.M.C., C.B.E., F.R.C.P. (Modern Medical Monograph.) (Constable.) Pp. 83. Price 7s. 6d.

This book, based upon the author's personal experience, is designed to show the therapeutic value of bacterial vaccines, indicating their uses and at the same time stressing their limitations. It is reactive to some of the far too optimistic accounts which have appeared on this subject. Naturally the book contains many controversial statements, particularly the author's method of preparing vaccines. The work should prove useful to those who require a guide on this difficult subject.

MODERN METHODS IN THE DIAGNOSIS AND TREATMENT OF RENAL DISEASE. By HUGH MACLEAN, M.D., D.Sc., F.R.C.P. Third Edition. (Modern Medical Monograph.) (Constable.) Pp. 135. Price 12s.

This book, which alludes only in the briefest manner to theoretical considerations, gives clear and concise information as to the diagnosis and treatment of nephritis. In no sense a text-book, the ordinary signs and symptoms of kidney disease are not discussed at length. The importance of regarding the severity and subsequent progress of the disease in terms of renal function is emphasized. A clear scheme for investigating cases by a combination of clinical observation and the use of renal function tests is given, which has the advantage of being both simple and practicable. The author stresses the importance of these tests, but confines himself to those few which are simple and of proven worth. The edition differs from previous ones by an added chapter on treatment, which sets forth a definite scheme with commendable clarity. Many may quarrel with the author's dogmatism, but none will deny the great value of this book in general practice.

GYNÆCOLOGY. By T. W. EDEN, M.D., C.M.(Edin.), F.R.C.P., F.R.C.S., and C. LOCKYER, M.D., B.S., F.R.C.S., F.R.C.P. Third Edition. (London: J. & A. Churchill, 1928.) Pp. 822. Illustrations, xxxii + 556. Price 36s.

The third edition of this work on gynaecology represents a very complete account of the subject, dealt with in a reasonably compact space. It is, perhaps, a little large as a text-book for the general student, but it will meet admirably the requirements of the students and practitioners for whom it is intended.

The revision of the second edition includes the extension of the section upon the anatomy and physiology of menstruation and the corpus luteum. Some of the work upon the subject proceeding from the hospital is featured. The recent researches upon ovarian tumours, notably endometriomata, are dealt with fully. The bacteriology and immunology of pelvic infections is discussed.

On the therapeutic and diagnostic side important additions have been made upon the subjects of diathermy, the treatment of carcinoma of the cervix and the use of tubal insufflation. The operative procedures have been revised.

The illustrations are excellent. The coloured plates are remarkably good, especially those dealing with histology. The book has been reduced in the number of its pages at the expense of the size of the page, which makes reading a little tedious in unrelieved pages. But the adverse criticism is of small importance compared with the general excellence of the book.

CLINICAL PATHOLOGY. By P. M. PANTON, M.A., M.B., B.C.(Cantab.), and J. R. MARRACK, M.A., M.D.(Cantab.). Second edition. (London: J. & A. Churchill, 1927.) Pp. 459. Illustrations, xii + 51. Price 15s.

Clinical pathology is an ill-defined branch of medicine, and those who write on the subject are liable either to overload it with detail outside the requirements of the average clinical pathologist, or to scamp the matter. This book preserves an admirable balance, especially between the chemical and other methods of examination. The chemical sections have been rewritten since the first edition, and all the recent advances in diagnostic methods included. The first section on blood is marred by carelessness in the registration of some of the coloured plates of blood-cells, which thereby destroys the value of the pictures as diagnostic aids; also by the representation of a neutrophil leucocyte, which possess too glaringly oxyphil granules.

The bacteriological sections are good, and the provisional classification offered by the authors provides a useful working basis; the

section on the examination of puncture fluids is clear and concise.

The urinary, alimentary and respiratory systems, together with a chapter on the skin and eyes, are fully treated from the point of view of biochemistry, bacteriology and parasitology.

The end chapter on histology is short, but fairly comprehensive, though perhaps biological methods might have received a little fuller treatment. But the book as a whole is good, and worth study.

TREATMENT BY MANIPULATION: A PRACTICAL HANDBOOK FOR THE PRACTITIONER AND STUDENT. By A. G. TIMBRELL FISHER, F.R.C.S. Second Edition. (H. K. Lewis & Co., Ltd.) Pp. 200. Illustrations 62. Price 9s.

The first edition of this book appeared under the title of "Manipulative Surgery." While regretting the change of name of a book which has become well known, we keenly await the announcement of the title of the third edition.

Mr. Timbrell Fisher does a great service not only to the medical profession but also to the general public in emphasizing the great part that adhesions in joints, following injury, play in prolonging convalescence or producing permanent disability.

There is a chapter on pathology which deals chiefly with the pathology of the formation of adhesions. Succeeding chapters deal with diagnosis and general principles of treatment, and then the various joints are taken in turn and discussed. In the case of each joint the surgical anatomy, the lesions benefited by manipulation and the exact manipulative technique are fully dealt with, in addition to accounts of numerous illustrative cases being given.

For many years bone-setters have done much good and much bad, and one cannot help feeling that the author of this book, with pathological and anatomical knowledge, has picked out the good and presented it very clearly in a way which the medical profession should appreciate and recognize much better than it does at present.

We can strongly recommend this book to all who have to do with the treatment of injuries and their sequelae.

We feel, however, that the usefulness of the book would be greatly increased if there were added paragraphs describing the manipulations for reducing dislocations of the various joints and for setting the common fractures. This could be done without greatly increasing the size of the volume.

The manipulative treatment of congenital dislocation of the hip and of club-feet is not dealt with.

The illustrations are excellent and there is a good index.

While reading the paragraphs condemning osteopathy, we were struck by the gap in the author's anatomical knowledge when he states (referring to defective vision and deafness) that "anyone with the most elementary knowledge of anatomy must be aware that the nerves of these organs do not originate in the spinal cord, neither do they pass through the intervertebral foramina." There is a sympathetic nervous system.

#### EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

The following degrees has been conferred:

D.M.—Gilkes, H. A.

First Examination, December, 1927.

Anatomy and Physiology.—Edelsten, G. G. M.

Final Examination for the M.B., B.Ch., December, 1927.

Materia Medica.—Matthews Duncan, C., Newton, R. D., Nicholson, J. C.

Pathology.—Molly, A. J. M.

Forensic Medicine and Public Health.—Gilding, H. P.

Medicine, Surgery and Midwifery.—Bertie, L. W. H., Gilding, H. P., Kingsley, A. P.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:

B.Chir.—Buttery, J. W. D.

M.B., B.Chir.—Cooper, W. F.

Second Examination for Medical and Surgical Degrees, Michaelmas Term, 1927.

Part II. Human Anatomy and Physiology.—Mainsa, M. H.

Third Examination for Medical and Surgical Degrees, Michaelmas Term, 1927.

Part I. Surgery, Midwifery and Gynaecology.—Ashby, W. R., Buckley, W., Dahne, S. F. L., Dunkerley, J. T., Gray, R. A. P.,



Lees, J. M., Lloyd, W. J., Palmer, E. A. E., Pimblett, G. W., Redmond, E. G., Richards, F. A., Smith, T. R., Smith, W., Spooner, E. T. C., Tweedie, D. R., Underwood, W. F., Ward, F. H.

*Part II. Principles and Practice of Physic, Pathology and Pharmacology.*—Armstrong, I. R., Barendt, G. H., Beattie, W. J. H. M., Briggs, W. A., Buttery, J. W. D., Eason, G. A., Gray, S. J. P., Harker, M. J., James, E. T., MacLay, W. S., Oakley, D. E., Pym, P. E., Robertson, J. B. W., Sinclair, M. R., Tweedie, D. R., Wilkin, W. J., Windeyer, R. M.

## UNIVERSITY OF LONDON.

M.D. Examination, December, 1927.  
*Branch III. Psychological Medicine.*—Atkin, I.  
 M.S. Examination, December, 1927.  
*Branch I. Surgery.*—Beyers, C. F.

## ROYAL COLLEGE OF PHYSICIANS.

The following have been admitted Members:  
 Anderson, R. G., Hutt, C. W.

## ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

The following Diplomas have been conferred:

Chadwick, N. E., Curnow, R. N., Hamilton, W. H., Johnson, R. S.  
 The following Diploma has been conferred:  
 D.P.H.

Frost, I.

The following Diploma has been conferred:  
 D.O.M.S.

Verling-Brown, C. R.

## CONJOINT EXAMINING BOARD.

*Pre-Medical Examination, January, 1928.*

*Chemistry.*—Featherstone, G. I. C. (Old Regulations), Tang, M. C.  
*Physics.*—Featherstone, G. I. C. (Old Regulations), Rassim, H. S., Savage, O. A., Tang, M. C.

*First Examination.*

*Part I. Anatomy.*—Mansl, J. A., McBride, J. R. B., Simmons, H., Vartan C. K.  
*Part I. Physiology.*—McBride, J. R. B., Simmons, H., Vartan, C. K.

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

Alsop, A. F., Beach, H. L. W., Broadbent, M. S. R., Cosgrove, E. C., Evans, M. J., Fraser, H. D. F., Gray, R. A. P., Hutt, W. L., Jenkins, D. C. R. R., Lloyd, W. J., McGladdery, S., Miles, A. A., Moore, C. F., Peltz, P. I., Raven, R. W., Seidenberg, H. A., Sinclair, C. G., van Rossum, G. P. A., White, H. O., Wroth, C.

## APPOINTMENTS.

BATTEN, I. W., M.B., B.Ch. (Cantab.), M.R.C.P., appointed Assistant Physician to the East London Hospital for Children, Shadwell.

BIRT-WHITE, H., M.D., F.R.C.S., appointed Surgeon to Out-Patients, Hospital for Women, Seho.

CASTLEDEN, L. I. M., M.B., B.S., appointed Junior Assistant Medical Superintendent, St. Pancras Hospital, N.W. 1.

CHAMBERLAIN, A. G., M.R.C.S., L.R.C.P., appointed Medical Officer to the Post Office at Charnmouth, Morecombe-lake, and Whitelchurch Canonichorum.

CRIDDEN, S. S., M.B., B.S., appointed Resident Medical Officer to the City of London Chest Hospital, Victoria Park.

SALT, P. G., M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the Hospital of St. John and St. Elizabeth, N.W. 8.

## CHANGES OF ADDRESS.

AINSWORTH-DAVIS, J. C., 89, Harley Street, W. 1. (Tel. Langham 2051.)

BLACKBAY, E. J., 26, Merivale Road, Harrow, Middlesex.

DOAKFORD, Major T. L., I.M.S., c/o Messrs. Grindlay & Co., Ltd., 6, Church Lane, Calcutta, India (from April, 1928).

LANDAU, J. V., General Hospital, Penang, Straits Settlements.

LEITCH, J. N., c/o Harehmere, Cavendish Road, Sutton, Surrey.

STURTON, S. D., 192, Range Road, Shanghai, China, via Siberia.

THOMAS, T. MEYRICK, 8, Harley Street, W. 1.

## BIRTHS.

ANDREWES. On February 14th, 1928, at 54, Brent Way, Church End, Finchley, to Kathleen (née Lamb), wife of Christopher H. Andrewes—a son (John Frederick).

BARNSELY.—On January 28th, 1928, at the General Hospital, Singapore, to Doris Winifred (née Shaw) and Arnold Barnsley—a daughter.

BILDERBECK.—On January 19th, 1928, at a nursing home, Littlehampton, Sussex, the wife of Major C. L. Bilderbeck, I.M.S., of a son.

BREWERTON.—On January 24th, 1928, at 73, Harley Street, to Olive, wife of Elmore Wright Brewerton, F.R.C.S.—a son.

BURS.—On February 6th, 1928, at Old Friars, Richmond, Surrey, to Nell, wife of Dr. J. S. Burs—a son.

HAMBLEN THOMAS.—On January 31st, 1928, at 26, Harley Street, to Eulalie (née Oliver), wife of C. Hamblen Thomas, F.R.C.S.—a son.

LYSN.—On January 26th, 1928, at 27, Welbeck Street, the wife of Major Rigby Lysn, D.S.O., I.M.S.—a son.

NEISON.—On February 10th, 1928, at 71, East Street, W. 1, to Kathleen (née Sullivan), wife of H. P. Neison, M.B.—a daughter (Jennifer).

ROSE.—On February 10th, 1928, at Lansdowne House, Romsey, Hants, to Mabel (née Davis), wife of Edward S. Rose, M.R.C.S.—a son.

TAIT.—On January 27th, 1928, at Archpool, Handcross, Sussex, to Joan (née Alford), wife of Greville Tait, M.A., M.B., B.Chir.—a son.

## SILVER WEDDING.

RUSSELL-STRIKER.—On January 28th, 1903, at St. Stephen's, North Bow, by the Rev. Prof. Mason, M.A., George Herbert Russell, M.R.C.S., L.R.C.P., second son of the Rev. John Russell, B.A., to Ethel Kate, eldest daughter of Robert Battam Striker.

## MARRIAGE.

BEVERIDGE-SHAW.—On January 11th, 1928, at Melbourne, Australia, C. Eric G. Beveridge, M.A., B.Sc., M.R.C.S., L.R.C.P., Sudan Medical Service, only son of Rev. S. A. Beveridge, Th.L., V.D., F.S.G., rector of Pinxton, to Ethel W. Shaw, youngest daughter of Mr. and Mrs. W. P. Shaw, of Toorak, Melbourne.

## DEATHS.

BENNETT.—On February 7th, 1928, at 36, Morpeth Mansions, S.W., Francis Dillon Bennett, M.R.C.S., L.R.C.P., Chevalier de la Légion d'Honneur, and for many years Medical Officer to the Army and Navy Stores, eldest son of the late William Christopher Bennett, M.I.C.E., of Honda, Sydney, N.S.W., and dearly loved husband of Mildred Bennett.

HOWELL.—On January 15th, 1928, at St. Bartholomew's Hospital, London, Trevor Howell, M.C., F.R.C.S.E., aged 50.

ROBINSON.—On January 29th, 1928, at his residence, 1, Avereng Road, Folkestone, suddenly, Louis Robinson, M.D., aged 70.

SHOOLBRED.—On January 25th, 1928, at St. Ann's, Chesham, William Andrew Shoobred, Surgeon.

## ACKNOWLEDGMENTS.

*Drawings*—British Journal of Nursing—British Journal of Venereal Diseases—Le Bulletin de Société Médicale—The Charing Cross Hospital Gazette—Clinical Excerpta—St. George's Hospital Gazette—Guy's Hospital Gazette—The Hospital Gazette—The Journal of the International Society of Medical Hydrology—The Journal of the Research Defence Society—The Kenya and East African Medical Journal—The London Hospital Gazette—The Long Island Medical Journal—St. Mary's Hospital Gazette—The Medical Journal of Australia—The Medical Review—The Middlesex Hospital Journal—The New Troy—The Nursing Times—The Post-Graduate Medical Journal—The Queen's Medical Magazine—Revue de Médecin—The Student—St. Thomas's Hospital Gazette—University of Toronto Medical Journal—U.C.H. Magazine.

## 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, E.C. 1.

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLIAMS, M.B.E., B.A., at the Hospital.

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0510.

## St. Bartholomew's Hospital



## JOURNAL.

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

VOL. XXXV.—No. 7.]

APRIL 1ST, 1928.

PRICE NINEPENCE.

## CALENDAR.

Tues., April 3.—Dr. Morley Fletcher and Sir Holburt Waring on duty.  
 Fri., „ 6.—Good Friday.  
 Sir Percival Hartley and Mr. L. B. Rawling on duty.  
 Out-Patient Department open for emergencies.  
 Sun., „ 8.—Easter Day.  
 Mon., „ 9.—Bank Holiday.  
 Tues., „ 10.—Out-Patient Department reopens as usual.  
 Sir Thomas Horder and Sir Charles Gordon-Watson on duty.  
 Fri., „ 13.—Dr. Langdon Brown and Mr. Harold Wilson on duty.  
 Tues., „ 17.—Prof. Fraser and Prof. Gask on duty.  
 Wed., „ 18.—Last day for receiving matter for the May issue of the Journal.  
 Fri., „ 20.—Summer Session begins.  
 Dr. Morley Fletcher and Sir Holburt Waring on duty.  
 Tues., „ 24.—Sir Percival Hartley and Mr. L. B. Rawling on duty.  
 Fri., „ 27.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.  
 Mon., „ 30.—Special Subject Lecture by Mr. Harmer.

## EDITORIAL.

**H**AKE, Editorial Pen, with whatever is left of you of romantic fervour in this age of materials and disillusion; scatter blots of joyous ink upon the editorial trousers; surge forward in unwieldy sentences to that welter of passionate phrases in which the shaly words "The Rugger Cup" are the only distinguishable entities; till you fall from our nerveless fingers, inkless, broken . . .

Four times we have won this Cup, and the names of T. C. Gibson, Charles O'Brien Harding, G. W. C. Parker and R. N. Williams will be tossed about by the toothless mouths of our descendants before ever they have learnt to lisp the rest of the alphabet; and even though we make it five next year, the close excitement of this season's games will not be diminished, nor the members of this team forgotten.

The following telegram (marked "urgent") from His Royal Highness shows his interest in the doings of the Hospital, as well as the national importance of the occasion:

"The Captain, Rugby Football Team, St. Bartholomew's Hospital.

"My heartiest congratulations to you all on your victory in Hospitals Cup yesterday.

"EDWARD P., President.

"Buckingham Palace."

Anyone who is unfortunate enough to have to pass through the Surgery on Monday mornings between the hours of 9 a.m. and 1 p.m. will have noticed that humanity is more than adequately represented, and that the familiar phrase "Standing room only" is a euphemism. On Monday, March 19th, a "record" was reached, 1077 out-patients being treated up to 4 p.m. The provision of Junior Casualty Officers appears to have resulted in enabling patients to be so well and comfortably treated that the temptation to give their panel doctors the slip has become irresistible. It is now no longer fashionable in Hoxton to remain on the panel. Panel doctors are not allowed to furnish any but panel prescriptions at a minimum price; why not, therefore, step round to the Hospital and obtain not only hist. gent. cum rheo, but even an elaborate and special prescription all to oneself? Why not? But this might constitute a quite appreciable addition to the Hospital expenditure, that it may become necessary for us to restrict ourselves more and more to stock prescriptions in the average case, and to cut out more and more the latest physical and chemical investigations in diagnosis. We have known more than one doctor who has been justifiably furious at a patient sneaking up to Hospital behind his back.

Our correspondence columns are open to any Old Bartholomew's men who would care to discuss this matter.