

HISTORY OF MEDICINE.

SINGERIST: *Great Doctors: A Biographical History of Medicine.*

MATERIA MEDICA.

BRUCE and DILLING: *Materia Medica and Therapeutics.*

MEDICINE.

BEAUMONT and DODDS: *Recent Advances in Medicine.* Seventh edition.CECIL: *Textbook of Medicine.* Third edition.
PRICE: *Textbook of the Practice of Medicine.* Fourth edition.
SAVILL: *A System of Clinical Medicine.* Ninth edition.

NERVOUS SYSTEM.

RANSOM: *Anatomy of the Nervous System.*
RUSSELL BRAIN: *Diseases of the Nervous System.*

OPHTHALMOLOGY.

YELD: *A Thesis on Accommodation in the Human Eye.*

ORTHOPEDICS.

MERCER: *Orthopaedic Surgery.*

PATHOLOGY.

BOYD: *Surgical Pathology.* Third edition.
TOPLEY: *An Outline of Immunity.*
WILLIS: *The Spread of Tumours in the Human Body.*

PHYSIOLOGY.

HALLIDURTON and McDOWALL: *Handbook of Human Physiology.* Thirty-third edition.
STARLING: *Principles of Human Physiology.* Sixth edition.

SURGERY.

GASK and ROSS: *The Surgery of the Sympathetic Nervous System.*
KANAVEL: *Infections of the Hand.* Sixth edition.
ROSE and CARLESS: *Manual of Surgery.* Fourteenth edition.

TREATMENT.

DONALDSON: *Radiotherapy in the Diseases of Women.*
HUTCHINSON: *Elements of Medical Treatment.* Second edition.
LAWRENCE: *The Diabetic Life.* Seventh edition.

TUBERCULOSIS.

MORRISTON DAVIES: *Pulmonary Tuberculosis: Medical and Surgical Treatment.*

EXAMINATIONS, ETC.

Conjoint Examination Board.

Final Examination, January, 1934.

The following students have completed the Examinations for the Diplomas of **M.R.C.S., L.R.C.P.**, and have had the Diplomas conferred on them:

BATLEY, J. S., BENISON, R. L., BINTCHIE, E. W., DANHO, E. A., DHARMASENA, C. B., EDWARD, D. G. ff., GALE, H. E. D., GEORGE, C. A., HATTON, P. L. S., HINDLEY, G. T., JOHNSON, D. J., JONES, E. G., JONES, P. A., KINGDON, J. R., PIRIE, A. H., POWELL, J. D., RASSIM, H. S., REAVELL, D. C., SABLIN, N. S., SHEEHAN, D. J., SMITH, M. C. L., STEPHENS, K. F., SUTTON, R. J. C.

APPOINTMENTS.

SMITH, SIR RUDOLPH HAMPDEN, BART, F.R.C.S., appointed Honorary Consulting Surgeon, Torbay Hospital, Torquay (having retired from the active Honorary Staff).
STEPHENS, D., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer, Oldchurch Hospital, Romford (Essex County Council).
TAYLOR, HERMON, M.Chir.(Cantab.), F.R.C.S., appointed First Assistant to Mr. A. J. Walton at the London Hospital.

CHANGES OF ADDRESS.

BUCHLER, E., 57, Bedford Road, S.W. 4. (Tel. Brixton 6366.)
MORGAN, R. G., 24, Stow Park Avenue, Newport, Mon.
WROTH, C., 45, Southernhay West, Exeter. (Tel. 3548.)

BIRTHS.

CARNEGIE BROWN.—On February 6th, 1934, to Ella, the wife of Dr. A. Carnegie Brown, of Ripon—a son.
DARMADY.—On February 1st, 1934, at 20, Devonshire Place, W. 1, to Mary (*née* Bird), wife of Dr. E. M. Darmady—a son.
GALLOP.—On February 16th, 1934, at Northfield, Elmstead Lane, Bickley, Kent, to Doris Ruth (*née* Gwatkin), wife of Dr. Edward Gallop—a daughter.
HOBDAV.—On February 18th, 1934, at 32A, Trebovir Road, Earl's Court, to Sezerina Néomi (*née* Radford), wife of Dr. F. T. J. Hobday—a son.
HOLMES.—On February 14th, 1934, at 57, Albert Road, Southport, to Phyllis, wife of John Holmes, M.B., M.R.C.P.—a daughter.
RAINEY.—On February 7th, 1934, at 149, Dereham Road, Norwich, to Margaret and Philip Rainey—a son.

MARRIAGES.

ECCLES—KEENE.—On February 15th, 1934, at the Register Office, Westminster, George Foltcher Eccles, M.A., M.B., B.Ch.(Cantab.), of Hove, to Gladys Elizabeth, elder daughter of Mr. and Mrs. A. Keene, of Whitston and Ashton-under-Lyne.
STEPHENS—FREDERICK.—On February 21st, 1934, at Holy Trinity Church, Brompton, Deri Stephens, M.R.C.S., L.R.C.P., to Kathleen Patricia Frederick, only daughter of the late Dr. E. G. Frederick.

DEATHS.

BRIGGS.—On February 1st, 1934, at Premier House, Gregory Boulevard, Nottingham, Florence Emily, the devoted wife of Dr. I. A. Oswald Briggs.
CAVE.—On February 16th, 1934, at 16, Circus, Bath, Edward John Cave, M.D., F.R.C.P., aged 74.
CHITTENDEN.—On February 7th, 1934, Thomas Hillier Chittenden, M.D., M.R.C.P., Barrister-at-Law, Lt.-Col. R.A.M.C. (retired), aged 78.
DUNN.—On February 7th, 1934, suddenly, at Tiverton, Devon, Spencer Graeme Dunn, F.R.C.S., B.Sc., etc., of 16, Adamson Road, N.W. 3.
MACKENZIE.—On February 10th, 1934, at sea on S.S. "Duchess of Richmond", Colin Mackenzie, O.B.E., M.A., F.R.C.S., of 11, Mornington Villas, Bradford.
SCOTT.—On February 20th, 1934, Leonard Rex Bodley, beloved son of Dr. L. Bodley Scott, of Blandford, Dorset, aged 22.
THOMAS.—On February 12th, 1934, in a nursing home in London, Dr. Harold S. Thomas, of London Road, Portsmouth, aged 58.

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: National 4444.

St. Bartholomew's Hospital



Journal.

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

VOL. XLII.—No. 7.]

APRIL 1ST, 1934.

PRICE NINEPENCE

CALENDAR.

Mon., April 2.—**Bank Holiday.**
Tues., ,, 3.—**Rugby Match v. Bristol.** Away.
Lord Horder and Sir Charles Gordon-Watson on duty.
Fri., ,, 6.—**Dr. Hinds Howell and Mr. Harold Wilson on duty.**
Sat., ,, 7.—**Rugby Match v. Torquay Athletic.** Away.
Mon., ,, 9.—**Rugby Match v. Redruth.** Away.
Tues., ,, 10.—**Rugby Match v. Falmouth.** Away.
Dr. Gow and Mr. Girling Ball on duty.
Fri., ,, 13.—**Dr. Graham and Mr. Roberts on duty.**
Sat., ,, 14.—**Rugby Football Club: Seven-a-Side Tournament and Dance in Aid of College Appeal.**
Tues., ,, 17.—**Prof. Fraser and Prof. Gask on duty.**
Fri., ,, 20.—**Lord Horder and Sir Charles Gordon-Watson on duty.**
Last day for receiving matter for the May issue of the Journal.
Mon., ,, 23.—**Special Subject: Clinical Lecture by Dr. Cumberbatch.**
Tues., ,, 24.—**Dr. Hinds Howell and Mr. Harold Wilson on duty.**
Wed., ,, 25.—**Surgery: Clinical Lecture by Sir Charles Gordon-Watson.**
Fri., ,, 27.—**Medicine: Clinical Lecture by Dr. Graham.**
Dr. Gow and Mr. Girling Ball on duty.

EDITORIAL.



THE Dean has sent us the following letter:

"DEAR MR. EDITOR,—It is with the greatest pleasure that I am able to announce that, through your columns, I have succeeded in getting four other Bart.'s men to subscribe 25 guineas a year for five years, as suggested by my old friend, Dr. Eric Young.

"Having got this far I am just wondering whether there are not a few more who might take the same line.

"Yours sincerely,

"W. GIRLING BALL,

"Dean of the Medical College."

COLLEGE APPEAL FUND.

	£	s.	d.	
Staff	12,342	14	10	(71)
Demonstrators	1,674	11	0	(67)
Students	712	0	5	(254)
Old Bart.'s men:				+
Bedfordshire	12	12	6	(4)
Berkshire	96	1	0	(14)
Buckinghamshire	74	19	0	(13)
Cambridgeshire	165	14	0	(13)
Cheshire	1	1	0	(1)
Cornwall	22	2	0	(5)
Cumberland	5	0	0	(9)
Derbyshire	10	14	0	(4)
Devonshire	547	4	0	(51)
Dorset	52	1	0	(14)
Durham	16	6	0	(3)
Essex	229	19	6	(17)
Gloucestershire	218	12	6	(20)
Hampshire	406	14	0	(38)
Herefordshire	13	3	0	(4)
Hertfordshire	73	0	0	(12)
Huntingdonshire				(1)
Isle of Wight	181	13	0	(12)
Kent	558	3	0	(64)
Lancashire	91	2	0	(11)
Leicestershire	133	12	0	(6)
Lincolnshire	47	0	0	(13)
Middlesex	382	3	0	(18)
Norfolk	159	7	6	(18)
Northamptonshire	54	4	0	(4)
Northumberland	101	1	0	(2)
Nottinghamshire	13	13	0	(2)
Oxfordshire	180	3	0	(17)
Rutland				(2)
Shropshire	55	9	0	(8)
Somersetshire	1013	10	0	(26)
Staffordshire	194	18	0	(6)
Suffolk	263	1	0	(16)
Surry	420	16	6	(16)
Sussex	272	2	0	(48)
Warwickshire	178	1	6	(18)
Westmorland	1	0	0	(1)
Wiltshire	97	11	0	(11)
Worcestershire	149	15	6	(21)
Yorkshire	279	4	6	(21)
Wales	56	4	0	(12)
London	2,742	11	8	(174)
Channel Islands	10	0	0	(1)
Scotland	14	4	0	(4)
Abroad	48	5	0	(7)
South Africa	326	10	6	(17)
Canada	113	2	6	(8)
East Africa	62	7	0	(5)
West Africa	146	10	0	(10)
Carried forward	£25,011	0	11	

	£	s.	d.	
Brought forward	25,011	0	11	†
India	152	0	0	(7)
Ceylon	4	0	0	(1)
Syria	2	2	0	(1)
U.S.A.	5	0	0	(1)
Ireland	14	14	0	(3)
North Africa	1	0	0	(1)
North Borneo	5	5	0	(1)
Australia	12	2	0	(3)
Egypt	4	2	0	(2)
Malay States	6	0	0	(2)
China	45	7	4	(7)
Siam	10	0	0	(1)
France	50	0	0	(1)
Trinidad	22	2	0	(2)
British West Indies	23	1	0	(3)
Kenya	19	0	0	(2)
New Zealand	2	1	0	(2)
Services	514	14	0	(33)
Others	31,592	12	7	(272)

£57,487 3 10

† Number of Bart's men in County.

It is over a year ago since Mr. Fitzmaurice kindly offered his services to the Hospital to teach scientific German to anyone who cared to attend organized classes. At the inaugural meeting over forty names were placed on the preliminary list, and it was suggested that a voluntary subscription should be raised at a later date among those who supported the lectures.

At the present time the attendances have become considerably reduced, but the time is now ripe when the proposed subscription should be raised. Mr. Fitzmaurice has suggested that the money collected should be given to that most deserving cause, the Samaritan Fund, and he himself has generously added his name as a donor to the list.

Will all those who put their names down at the preliminary meeting try to support this scheme and give their subscriptions to Bridle?

Dr. Philip Gosse needs no introduction to readers of the JOURNAL. His anecdotes on Mrs. Dwiggin, The Woodpecker, Dental Misadventures, etc., which appeared in these pages last year, are well known and it gave us great pleasure when we heard that he was publishing his war experiences in the form of a book.

Dr. Gosse is both a man of letters and a naturalist, but after reading his *Memoirs of a Camp Follower* we realized that he was something more—he is an artist. It is an artist who combines the wit, humour, beauty, beasts and birds into this literary picture; he mingles tragedy with comedy.

In the later columns of this issue we have published an annotation on this the latest of his handiwork, and after congratulating Dr. Gosse, we would advise

everybody to procure a copy and read it during their leisure hours. Copies can be obtained through the Librarian.

Rugger Seven-a-Side Tournament.

We have been asked to remind readers that the Second Annual Inter-Firm Seven-a-Side Tournament and Residents v. Chief Assistants Match will be held at Winchmore Hill on the afternoon of Saturday, April 14th.

In the evening a Dance will be held at 16, Bruton Street, and the funds raised on the day will be given to the College Appeal Fund.

Please come and bring your friends.

TENTH DECENNIAL CLUB.

We have been asked to announce that the Annual Dinner of the Tenth Decennial Club will be held at the Café Royal on Friday, May 4th, 1934. Dr. Geoffrey Evans will be in the Chair. Will any members requiring further information please apply to one or other of the secretaries, Mr. Reginald M. Vick or Dr. Arnold W. Stott?

THE ELEVENTH DECENNIAL CLUB.

The Sixth Annual Dinner of the Eleventh Decennial Club will be held on Friday, April 20th, at the Café Royal, with R. Hunt Cooke, Esq., M.D., M.R.C.P., in the Chair. Will those who have not received notices communicate with the Honorary Secretaries, Wilfred Shaw, 31, Weymouth Street, and F. C. W. Capps, 99, Harley Street?

Congratulations to the Boxing Team and the Soccer XI on winning the Inter-hospitals Cups.

HOUSE APPOINTMENTS.

The following gentlemen have been nominated to House Appointments from May 1st, 1934:

Junior House Physicians

Lord Horder	G. O. A. Briggs.
Prof. F. R. Fraser	D. M. Thomson.
Dr. C. M. Hinds Howell	J. Smart.
Dr. A. E. Gow	D. G. H. Edward.
Dr. G. Graham	C. M. Carr.

Junior House Surgeons—

Prof. G. E. Gask	G. Weddell.
Sir Charles Gordon-Watson	C. W. John.
Mr. Harold Wilson	P. H. R. Guey.
Mr. W. Girling Ball	R. J. C. Sutton.
Mr. J. E. H. Roberts	S. J. Hadfield.

Intern Midwifery Assistant (Resident)	W. M. Capper.
Intern Midwifery Assistant (Non-Resident)	E. M. Darnady.
Extern Midwifery Assistants	A. C. L. Houlton.*
H.S. to Throat and Ear Department	D. O. Davies.†
H.S. to Ophthalmic Department	S. E. Birdsall.
	J. A. Chivers.

H.S. to Skin and Venereal Departments	{ C. S. Hall-Smith.*
(Non-Resident)	{ G. T. Hindley.†
H.S. to Orthopaedic Department	R. T. Simcox.
Senior Resident Anaesthetist	B. Rait-Smith.‡
H.P. to Children's Department	A. E. Francis.
Junior Resident Anaesthetists	{ A. H. Picie.
	{ F. E. Wheeler.
Non-Resident Anaesthetist	J. H. West.
	{ F. Avery Jones.*
	{ H. E. D. Gale.*
Casualty House Physicians	{ K. F. Stephens.*
	{ C. H. Bateman.†
	{ A. Kanaar.†
	{ J. R. Kingdon.†
Casualty House Surgeons	{ H. B. Lee.*
	{ C. B. M. Warren.†
Dental House Surgeon	H. Parker Rees.
	‡ 3 months, May. † 3 months, August. ‡ 1 year.
	Others for 6 months.

CASES FROM THE WARDS.*

"Persistently increased frequency of micturition is commonly the earliest symptom of tuberculosis of the kidney."



HE following two cases are of clinical importance, as they both illustrate the truth of the above statement:

CASE I.

Male, at. 18; warehouseman. Admitted September 1st, 1933. "Passing urine frequently."

History.—Quite well until six months ago, when increased frequency of micturition started, which has continued until now, gradually getting worse. Other symptoms have been trivial.

Pain: Occasionally a little at the tip of the penis.

Difficulty of micturition: None.

Frequency of micturition: D/N = ½-1-hourly/3-4.

Stream: Normal.

Urine: Noticed to be cloudy recently; hæmaturia four days ago only; small amount at the end of micturition, and lasted one act only.

Examination.—Very healthy-looking patient.

Chest: No abnormality discovered.

Abdomen: Left ureter palpable over the pelvic brim. Right kidney just palpable.

Prostate: A small nodule on the left side.

Temperature 99.2°, pulse 84, respirations 18.

Investigations.

Urine.—Pus-cells present in large numbers; cultures sterile.

Tubercle bacilli: Seven specimens of urine examined; negative in six; the seventh contained tubercle bacilli in large numbers.

* Notes of a Clinical Lecture delivered at St. Bartholomew's Hospital on Wednesday, November 29th, 1933.

§

Urea Concentration Test.

	Urea.	Quantity of urine.
1st hour	2.30%	65 c.c.
2nd "	2.40%	80 "
3rd "	2.60%	66 "

X-rays.—Plain films: No abnormality seen.

Uroselectan: Right kidney—normal pelvis and concentration; left kidney—dilated ureter, early hydro-nephrosis and ulceration of the upper calyx.

Cystoscopy.—Under anaesthetic. Bladder held 10 oz.



CASE I.—INTRAVENOUS PYELOGRAM.

Right ureteric orifice: Normal appearance, but displaced beyond the mid-line to the left side of the bladder.

Left ureteric orifice: Wide open; typical "golf-hole"; pulled up to the left; mucosa around it red and injected.

Treatment.

Nephrectomy and complete ureterectomy.

Discharged October 10th, 1933, after an uninterrupted recovery from the operation. F. = D/N = 2-hourly/1-2. Urine almost clear. Sinus nearly healed. Nodule in prostate not obvious.

January, 1934: F. = D/N = 2-hourly/1. Sinus healed.

CASE 2.

Male, at. 35; hotel porter. Admitted August 18th, 1933. "Greatly increased frequency of micturition and pain in the back."

History.—Five months ago noticed that he could only hold his water for 30 minutes, this frequency being present day and night. At this time he had a dull pain in the groin and penis, often at night. The urine also was sometimes thick, and on one occasion was blood-stained.

He was taken into hospital for investigation. X-rays and cystoscopy revealed no abnormality. The urine was examined for tubercle bacilli, but none were found. No active treatment was carried out. The condition of the patient was improved as a result of the rest in bed, but the increased frequency of micturition persisted.

August, 1933: An exacerbation of the previous symptoms occurred, and in addition he developed a bad pain in the left loin.

On admission his symptoms were as follows:

Pain: A dull ache in the left loin, not relieved by rest.

Difficulty of micturition: Nil.

Frequency of micturition: D/N = $\frac{1}{2}$ -hourly/3-4.

Urine: Thick.

Stream: Good.

Examination.—Looks ill. Temperature 99°6', pulse 84, respirations 20.

Chest: No abnormality discovered.

Abdomen: A very large swelling in the region of the left kidney, reaching from under the costal margin almost to the iliac crest; very tender; no superficial oedema. Right kidney just palpable.

Progress.—As a result of the rest in bed the swelling in the left loin tended to subside somewhat, but the temperature still remained up, swinging up to 102°2'.

Investigations.

Urine.—Pus in large amount; cultures sterile.

Tubercle bacilli: Sixteen 24-hour specimens examined; tubercle bacilli present in small numbers in two and in large numbers in one specimen.

Blood-urea: 36 mgrm. %.

Urea Concentration Test.

	Urea.	Quantity of urine.
1st hour	2'40%	72 c.c.
2nd "	2'75%	77 "
3rd "	3'05%	50 "

X-rays.—Plain films: Right kidney appeared normal in shape and size. Left kidney not defined.

Uroselectan: Right kidney—normal concentration and normal renal pelvis.

Left kidney—almost no concentration; ? some calcification in the kidney.

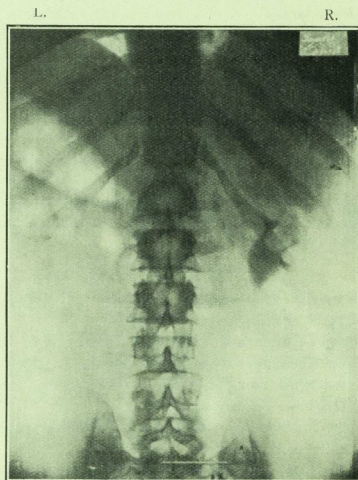
Cystoscopy.—Bladder held 10 oz. of fluid.

The right ureter dragged towards the mid-line, but normal in appearance.

The left ureteric orifice dragged upwards and outwards, the mucosa around the orifice being reddened and injected; no ulceration.

Treatment.

Perinephric abscess drained. Four ounces of thick, yellowish green pus evacuated. The pus was sterile on cultivation; no tubercle bacilli found. Wound packed.



CASE 2.—INTRAVENOUS PYELOGRAM.

Packing removed three days later, but a nephrectomy was considered to be inadvisable, and the wound was sewn up.

The temperature immediately settled. The patient got better and left the hospital four weeks after his operation.

November 1st, 1933: Seen as an out-patient. Sinus present; only small amount of discharge. Patient very well.

F. = D/N = 2-hourly/3-4. Urine still turbid and purulent. Left kidney palpable.

Advised to have the left kidney removed in three months' time.

The diagnosis of tuberculous disease of the kidney may be difficult, especially in the early stages. It is

important to recognize the condition at an early stage in order to get satisfactory results from surgical treatment.

The following facts are to be gathered from these cases:

(1) The symptoms had been present for an equal period of time in the two cases, yet the former shows relatively early, the latter advanced disease.

(2) Persistently increased frequency of micturition was, as it commonly is, the earliest symptom. It is impossible to place too much emphasis on this statement.

This frequency is characteristic and almost pathognomonic, for in addition to being present both during the day and the night, it persists over a long period. The significance of this point appears to have been recognized by the first investigator of the second case, for all his investigations were directed towards establishing the diagnosis of tuberculosis.

The doctor of the first case was not, however, aware of the importance of the symptom, for he considered that the boy's bladder contained a vesical calculus. It is rare for a stone to cause serious nocturnal disturbance.

Increased frequency of micturition is, of course, a symptom of any inflammatory condition of the bladder, but with infections other than tuberculosis it is usually transitory and seldom so severe.

Perhaps it would be correct to say that with tuberculous infection the increased frequency is gradual in its onset, progressive, persistent and severe, whereas with other infections in the acute stage the onset is sudden, severe, diminishing and tending to disappear, even though the infection remains.

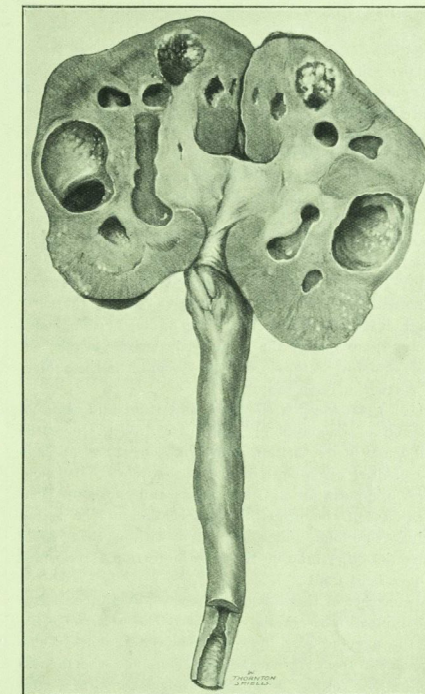
(3) The next lesson to be learned from these two cases is that a urine containing pus, in which bacteria cannot be demonstrated by the usual simple bacteriological investigations, is invariably associated with tuberculous infection.

(4) These two points taken together, namely, a persistently increased frequency of micturition with a sterile pyuria, almost amount to an axiom that the patient is suffering from tuberculosis of the urinary tract, and every effort should be directed to obtaining support for this diagnosis.

(5) It is often necessary to show great diligence and much patience in order to demonstrate the tubercle bacilli in the urine in these cases; it is obviously an important investigation to make, for if the bacilli are found the nature of the infection is clearly defined. As a matter of fact, the bacilli can almost always be demonstrated. But it must be remembered that one or two failures to find them must not negative the diagnosis.

In one of these cases seven and in the other sixteen observations were required before the bacilli were found.

This is a common experience. Again, considerable care must be exercised in identifying the bacillus, especially in the female patient, for it is easily mistaken, even by experts, for the smegma bacillus—a micro-organism of no importance. In cases of doubt, especially if the clinical findings do not fit in with the diagnosis, an attempt should be made to grow the bacilli



SPECIMEN REMOVED AT OPERATION (CASE 1).

on artificial media, or an inoculation into a guinea-pig should be resorted to. Either of these procedures delays the diagnosis being made.

(6) Fortunately it is not essential for the recognition of tuberculous disease of the urinary tract that the bacilli should be demonstrated. There are other phenomena which, singly or in combination, suffice to enable a diagnosis to be made.

(7) The text of this lecture is that this type of increased frequency of micturition is commonly the first symptom

of tuberculosis of the kidney. It is, of course, a vesical symptom, but experience has taught us that vesical tuberculosis is very rarely, if ever, a primary lesion in the urinary tract: it is almost invariably secondary to a primary unilateral lesion of the kidney. Thus, the symptom indicates renal disease. Failure to recognize this fact will delay the removal of the kidney—the appropriate treatment called for. Still, there are a few cases, especially in the male, in which the genital organs house the primary focus. This must not be forgotten.

(8) The next step, therefore, is to discover which kidney is involved. Do not be put off by the fact that the patient has no renal pain. Kidney symptoms are quite commonly absent, even with the most severe degree of renal tissue destruction. In the first case, for example, the patient had no pain at all, although, as you will observe in the accompanying drawing, there was considerable damage to the kidney tissue. In the second case the pain was a symptom of secondary importance until the formation of the perinephric abscess caused it to become severe.

(9) The presence of a large kidney on abdominal examination is, of course, suggestive, but in the early stages it is rarely discovered. The finding of a thickened ureter running over the brim of the pelvis may be the only evidence as to which kidney should be the subject of further investigation.

(10) Cystoscopy is the most important and essential method of diagnosis in these cases. With increased frequency of micturition as a symptom some lesion in the bladder will almost invariably be found. If hæmaturia or pyuria are also symptoms and cause sufficient turbidity of the urine, the observation of the turbid efflux from one ureter compared with a clear efflux from the other may be the only indication as to which kidney is at fault.

In neither of these cases was there a definitely active tuberculous focus in the bladder. The ureteric orifice of the affected side, however, showed a marked displacement from its normal situation, and the mucosa around its orifice was very congested. From this appearance it was recognized which kidney was the seat of disease and, moreover, that it was due to tuberculosis, for although there were no tubercles, ulcers, etc., the displacement of the ureteric orifice, caused by the thickened and shortened ureter, and the drawing upwards of the corresponding side of the bladder, was characteristic. This appearance is not caused by other diseases.

(11) The second point in connection with the cystoscopic examination was that the ureteric orifice and surrounding bladder mucosa on the sound side was normal; in both cases, however, they were displaced

beyond the middle line owing to the dragging upwards of the diseased side of the bladder. This observation was of major importance, as demonstrating that the lesion was probably unilateral. True, tuberculous nephritis is usually a unilateral condition, but the radical operation of removal of a kidney must not be considered unless there is a reasonable assurance that the opposite kidney is sound. Lesions of the bladder mucosa around both ureteric orifices must lead the surgeon to treat the case with great respect. The involvement of both ureters in the vesical inflammation suggests a bilateral infection; but remember, this may not be so. On more than one occasion after finding this condition the patient has been put to bed for a period. A subsequent cystoscopic examination has shown that lesions cleared up on one side and left a normal ureteric orifice on a clear bladder mucosa, thereby indicating the unilateral character of the disease. This has been subsequently proven by the after-history after removal of the affected kidney.

(12) At this stage sufficient evidence was available to show which kidney was affected. However, still further confirmation was sought:

(a) Straight radiograms were obtained, as they sometimes show calcareous or caseous areas in the affected kidney. In these cases the examination gave negative results, although there was a suggestion of caseation in the second case.

In cases of doubt as to which kidney is the seat of disease, radiography may be the only means of settling the matter, especially in cases of closed tuberculosis, where bladder lesions are commonly absent. This investigation, therefore, should never be omitted.

(b) A uroselectan pyelogram was also obtained. The findings in the two cases were different. In one case dilatation and ulceration of the renal pelvis and ureter were seen, with good concentration of the dye; in the other the dye did not concentrate in the diseased kidney.

In judging the function of a kidney, too much reliance must not be placed on the appearances seen in a uroselectan pyelogram. This fact is here demonstrated, for the kidney of the first case subsequently proved to be very seriously damaged. The additional obstruction at the ureteric orifice in the bladder no doubt led to this appearance in the picture. The test, however, was of value, as it showed a normal renal pelvis in the opposite kidney in both cases, which the previous cystoscopic findings had suggested was the case.

(13) The urea concentration tests were normal in both cases, and justified me, with the other findings by radiography and cystoscopy, in advising removal of the diseased kidneys, with the almost certain assurance that

if this could be carried out the prognosis would be favourable.


(14) There is still a very widespread impression that tuberculosis of the urinary tract is an incurable disease. This is not true provided the diagnosis is made early, if possible before the bladder has become seriously involved, and always provided that it is a unilateral lesion. These cases are examples which tend to disprove this belief.

The first case illustrates the advantage of an early diagnosis, as it was possible to remove the affected kidney and ureter and provide for a short convalescence, with the result that within six months of the operation the patient is quite well. He is able to hold his water for two hours, and can go through the night only passing it once. This will improve.

In the second case the diagnosis was made at a later stage of the disease. Had it been made at the time of the original investigation it is possible that an equally favourable result might have been obtained, instead of the patient being left with his diseased kidney still inside him. There is no doubt that before he gets well the kidney will have to be removed, but until the perinephritis has settled down this is almost an impossibility. Many months have been wasted, and the period of convalescence must be prolonged.

W. GIRLING BALL.

MEDICINE IN HORACE WALPOLE'S LETTERS.*

 HORACE WALPOLE'S long life (1717-1797) covered the greater part of the eighteenth century. He was not an altogether estimable character, being essentially a dilettante and a gossip, and something also of a snob, but he was a shrewd observer of men and manners, and he recorded his observations and reflections in an immense number of admirable letters, which form his chief title to fame. These letters throw a vivid light on the political and social life of the period, and it might have been expected that they would throw light on eighteenth century medicine also, especially as the letter-writers of that time were always fond of discussing matters of health. But this expectation is only partly fulfilled, for,

* Read before the Abernethian Society, February 23rd, 1933. Reproduced by permission of the Editor of the *Annals of Medical History*.

considering the volume of his correspondence, there is not a great deal of medical interest to be gleaned from it. Nor are the reasons for this far to seek. In the first place Walpole was not scientifically minded; his main interests were political, literary and artistic; and, secondly, he had no friends in the medical profession. He was quite unlike his contemporary, Samuel Johnson; he did not admire doctors and cultivate their society. On the contrary, he says that he "abhorred" physicians, and he was never tired of pouring ridicule and contempt upon them. He speaks of "the nonsense of physicians", and boasts that he almost never consulted one in his life. "The Jesuits are fallen," he writes, "but the time is not come for rooting out our physicians". When he heard of the sudden death of the poet Gray (from alleged "gout in the stomach"), and that Plumtre, the Regius Professor of Physic at Cambridge, had refused to get out of bed in the middle of the night to attend him,* Walpole exclaims, "Jesus! is their absence to murder as well as their presence?" He says in one letter, "Consider that the physicians recommend wine (in gout) and then can you doubt of its being poison?"; and in another ". . . a little after I die the secret will be found out of how to live for ever—and that secret, I believe, will not be discovered by a physician". These quotations are representative of his general attitude, but he has a shrewder dig at us when he writes, referring to certain politicians, "they choose to seem to deliberate like physicians who retire into another room and there talk news". Our only consolation is that he thought almost as badly of other professions: "In physicians I believe no more than in divines", and again, "Sure, the Devil's three names of Satan, Beelzebub and Lucifer were given to him in his three capacities of priest, physician and lawyer".

Walpole was not alone in holding a low opinion of the physicians of his day; Lady Mary Wortley Montagu, for instance, though they agreed in little else, says much the same kind of things about doctors in her letters as Walpole does in his, and when we consider the backward state of medicine in the eighteenth century we cannot be surprised.

Just as Lady Mary, however, admired one doctor, a country practitioner in Italy, so Walpole believed in one physician, Johnson's friend, Dr. Robert James. He never tired, at all events, of praising James's well-known powder, and both took it himself and recommended it to his friends. He had such a belief in the efficacy of the remedy that he said he would take it "if the house were on fire", and that "he almost believed it would cure anything but the villainy of

* Plumtre was a very old man and was obliged to refuse all night work.

physicians". In 1764 we find him writing to Mr. Churchill:

"The cure performed by James's powder charms me more than surprise me. I have long thought it could cure everything but physicians."

And ten years later to the Rev. William Cole:

"Your illness, dear Sir, is the worst excuse you could make me; and the worse, as you may be well in a night, if you will, by taking six grains of James's powder. He cannot cure death, but he can most complaints that are not mortal or chronic."

On another occasion he writes to his friend Sir Horace Mann:

"Lord Waldegrave is just dead of the smallpox. . . . He was taken ill on the Wednesday, the distemper showed itself on the Friday, a very bad sort, and carried him off that day se'night. His brother and sister were inoculated, but it was early in the practice of that great preservative, which was then devoutly opposed; he was the eldest son and weakly. He never had any fear of it, nor ever avoided it. . . . He died as he lived, the physicians declaring that if anything saved him, it would be his tranquillity; I soon saw by their ignorance and contradictions that they would not. Yet I believe James's powder would have preserved him. He took it by my persuasion, before I knew what his disorder was, but James was soon chased away, to make room for regular assassins. In the course of the illness nobody would venture to take on them so important a hazard as giving the powder again; yet in his agonies it was given and even then had efficacy enough to vomit him; but too late!"

GOUT.

But the chief medical subject discussed in the *Letters* is gout, and indeed the constant references to it become almost wearisome. As he says himself, "I can talk gout by the hour"—and he does, or at least by the page. This was natural enough, for he suffered severely from the disease himself throughout most of his life. He had his first attack, which nobody at the time believed was gout, at the age of thirty-six, and he continued to suffer from it till his death. Here is his account of the onset of his second attack in August, 1760:

"I have been out of order this fortnight, without knowing what was the matter with me; pains in my head, sickness at my stomach, dispiritedness and a return of the fever I had in winter. . . . on Monday morning I was seized as I thought with the cramp in my left foot; however, I walked about all day: towards evening it discovered itself by its true name, and that night I suffered a great deal. . . . Nobody would believe me six years ago when I said I had the gout. They would do leanness and temperance honours for which they have not the least claim."

The disease took in him the classical form, beginning in the foot and afterwards involving the knees, wrists, elbows and finger-joints. At first the attacks were biennial but later they became annual, and towards the end of his life he was much crippled by it, and greatly troubled with tophi. He said he "had more chalk stones than joints in his fingers and that he must set up an inn, for he could chalk a score with more ease and rapidity than any man in England". In January, 1786, we find him writing to Sir Horace Mann:

"I think, my dear Sir, that you will be glad to hear that I am getting free from my parenthesis of gout, which, though I treat it

as an interlude, has confined me above six weeks, and for a few days was very near being quite serious. It began by my middle finger of this hand, with which I am now writing, discharging a volley of chalk, which brought on gout and inflammation, and both together swelled my arm almost to my shoulder. In short, I was forced to have a surgeon. But last week my finger was delivered of a chalk-stone as big as a large pea, and now I trust the wound will soon heal."

And again in September, 1793:

"I have been very ill with gout for above a month; it began in my right hand, the middle finger of which opened, and discharged a sharp-pointed chalk-stone, that literally weighs four grains and a half."

Like everybody else, he had his own theory as to the nature of gout, which he expounds to the Rev. William Cole:

"How there can be a doubt what the gout is, amazes me! What is it but a concretion of humours, that either stop up the fine vessels, cause pain and inflammation, and pass away only by perspiration; or which discharge themselves into chalk-stones, which sometimes remain in their beds, sometimes make their passage outwardly? I have experienced all three. It may be objected that the sometimes instantaneous removal of pain from one limb to another is too rapid for a current of chalk—true, but not for the humour before coagulated. As there is, evidently, too, a degree of wind mixed with the gout, may not the wind be impregnated with the noxious effluvia, especially as the latter are pent up in the body and may be corrupted?"

In the management of his "gouts", as he termed them, he relied on temperance and cold water, used both externally and as a beverage. For the external use of cold water he had the precedent of Harvey, who, it will be remembered, used to immerse his gouty foot in a bucket of it, but Walpole does not recommend its use by everybody. He says in one letter (September, 1793): "An account is come of the sudden death of Lord Buckinghamshire: he had the gout in his foot, dipped it in cold water, and killed himself," and then he adds, with one of his few lapses into bad grammar, "nobody can play such tricks with impunity but I"*. He did not much believe in Bath, which was then so fashionable as a spa for the gouty. "Bath is excellent," he says, "for those who are in travail of the gout and seek a fit as a composition for subsequent health, but I certainly have no occasion to accelerate the attacks". Nor does he seem to have taken any drugs for the disease. Colchicum was not in use at that time, and opium was considered harmful, so there was no way of relieving the pain. His great local remedy was what he quaintly terms the "bootikins". These seem to have been a sort of fingerless flannel glove or sock in which he had the greatest faith. He believed that their use both prevented and shortened the attacks, so that

* Warner, whose book will be referred to later, had no doubt of the inexpediency and danger of cold bathing in gout: "It is so likely," he quaintly says, "to exasperate the Humours by the Tumult it occasions and to translate them crude and undigested upon some of the Nobler Organs, that none besides the young in Gout as well as in Years should ever venture upon it". Cold water as a drink for the gouty he thought "crude and pernicious".

the gout made "its grand tour" of his limbs in one month instead of five. "Surely," he says, "if I am laid up but one month in two years instead of five or six, I have reason to think the bootikins sent from heaven". And again:

"The bootikins do not cure the gout, but if they defer it, lessen it, shorten it, who would not wear them? Why, fine people, younger people, who will not condescend to lie like a mummy; nay, nor any body else, for the physicians and apothecaries, who began by recommending them, now, finding they are a specific, cry them down. . . . and will be believed, precisely because they lie; they say they weaken; it is false; I can at this moment stamp on the marble hearth with both feet with no more inconvenience than I did at five-and-twenty, which I never saw one other person that could do, who had the gout a twelvemonth before. I do this ten times a day to convince people; yet, what is ocular proof against the assertion of a grave face and a tied wig? If weakness were the consequence, who would be weakened so soon as I, who have bones no bigger than a lark's?"

Naturally he was always trying—though not always with success—to persuade his gouty friends to use the bootikins too, and in January, 1775, we find him writing to Mann, "I want to send you a cargo of bootikins; tell me the shortest way of conveying them". The physicians, of course, did not approve of this amateur remedy, for, as Johnson said, "physicians do not love intruders". "These rogues," says Walpole, in his polite way of referring to doctors, "persuade people that the bootikins are fatal. They now assert that my friend, Lady Hervey, who died of a diarrhoea, was killed by the bootikins she wore for the gout. All they can do is to keep up perspiration, which everybody knows is the only thing that can be done for the gout".

The frequency of gout amongst the upper classes in the eighteenth century is very remarkable, and there is convincing evidence of it not only in these letters, but in all the records of the social history of the period. Everybody who was anybody seems to have suffered from it. Dr. Ferdinand Warner, LL.D., who, though not a medical man, wrote an excellent popular treatise* on the disease, published in 1769, speaks in his preface of the "gentlemen and ladies who have the honour to have the gout". He says that he "jocosely" calls it an honour "because it is seriously affirmed that it is the inheritance only of the acute and sensible though others possibly may acquire it".

This is just another version of the old description of gout as "dominus morborum et morbus dominorum", which is probably still true, but why it was so common in Walpole's day as compared with now is a mystery. Perhaps there were more "domini" then, but the usual explanation is that people ate and drank more in those

* *A Full and Plain Account of the Gout*. By Ferdinand Warner, LL.D., London, 1768. From whence will be clearly seen, the Folly or the Baseness, of all Pretenders to the Cure of it: In which every-thing Material by the Best Writers on that Subject is taken notice of; and accompanied with some New and Important Instructions for its Relief, which the Author's Experience in the Gout above Thirty Years hath induced him to impart.

days. No doubt many of them did, and Warner states that "he thinks gout has increased tenfold in England since port, Madeira, sherry and other inflammatory wines have come so much into use". (On the other hand, it is interesting that the anonymous medical author of a *Treatise on Gravel and Gout*, published in 1787, recommends these very wines as the safest in gout because they contain least tartar!) But anyhow, by no means all of the sufferers from gout could be described as intemperate. Walpole himself is a case in point. He says somewhere that he lived "like an anchorite", and we are told by one of his biographers that "his dinner when at home was of chicken, pheasant or any light food of which he ate sparingly. Pastry he disliked as difficult of digestion though he would taste a morsel of venison pie. Iced water, then a London dislike, was his favourite drink".

It is true that he took no exercise, but he was very active and was much on his feet, and Pulteney said of him that "he ran like a peewit!" It may be suggested that he inherited the disease, but he rejects this explanation himself. "If either my father or my mother had had it," he says, "I should not dislike it so much. I am herald enough to approve it if descended genealogically; but it is an absolute upstart in me, and what is more provoking I had trusted to my great abstinence for keeping me from it. . . ."

There are two fallacies here, however. In the first place his putative father, Sir Robert, although he did not have gout, was greatly afflicted with stone, and, secondly, there is some doubt whether Sir Robert really was his father at all and whether he was not an illegitimate son of Lord Hervey by Lady Walpole, in which case he might easily have inherited the disease. But is gout inherited? One can understand the inheritance of a gouty "constitution", but to produce the disease there must be an exciting cause, and in Walpole's case at least that seems to have been absent.

Another mystery is the question of "misplaced" or "irregular" gout, to which there are many references in the *Letters*. Walpole says that in the course of twenty years he had only had gout "one half-hour in the head and never in the stomach", but he often speaks of it in these situations in others. What was meant by "misplaced" gout? Warner is fairly clear on the point. He says that "irregular" or "misplaced" gout may affect the stomach and intestine, producing loss of appetite, indigestion, vomiting, colic, dysentery, diarrhoea, and sometimes "gouty abscesses or imposthumes"; the head, in the form of vertigo or apoplexy; the nerves, producing palsies, and the organs of respiration in the form of asthma, cough or phthisis. Walpole himself regarded gout as a great impersonator of other

diseases. He writes, for instance, to Sir Horace Mann (August, 1785):

"Your philosophic account of yourself is worthy of you. Still, I am convinced you are better than you seem to think. A cough is vexatious, but in old persons is a great preservative. It is one of the forms in which the gout appears, and exercises and clears the lungs. I know actually two persons, no chickens, who are always very ill if they have no annual cough. You may imagine that I have made observations in plenty on the gout; yes, yes, I know its ways and its jesuitic evasions. I beg its pardon, it is a better soul than it appears to be; it is we that misuse it: if it does not appear with all its credentials, we take it for something else, and attempt to cure it. Being a remedy, and not a disease, it will not be cured; and it is better to let it have its way. If it is content to act the personage of a cough, pray humour it: it will prolong your life, if you do not contradict it and fling it somewhere else."

It may well be doubted whether many of the diseases and symptoms attributed to irregular gout were really due to that disease at all. None the less, it is wise not to be too dogmatic, for we are told by Warner, and other writers on gout agree with him, that "from the first appearance of these internal symptoms there is little or no gout in the extremities", but that they disappear at once "if weather or medicine restores a regular fit of the gout", and he says that "steel powders are the most effective remedy for expelling the disease from the organs to the extremities". If these observations are accurate—and we have no reason to doubt them—there may have been something in "misplaced gout" after all. Walpole, at least, was always afraid of driving it from the extremities to the internal organs by too active treatment, and warns some of his correspondents of this danger. He recognized, too, the apparent power of gout to prevent the patient getting other ailments, and speaks of it in the letter quoted above as a "remedy and not a disease". General experience has endorsed this view.

INOCULATION.

Although gout is the disease most often spoken of in the *Letters*, there are references to some others. Smallpox, that scourge of the century, naturally comes in for notice. Inoculation for it became fashionable in 1720, and Walpole was inoculated himself at the age of seven. Throughout his life he remained a strong advocate for the method, and much as he disliked Lady Mary Wortley Montagu, he has the magnanimity to speak of her "as a universal benefactress" for her introduction of it. He was never tired of defending it, and in a letter to Mann in 1783 he expresses "his zeal for the cause of inoculation" and denies that Prince Octavius died from it. Some years earlier (1767) he had written to the same correspondent:

"I wonder all the Princes of Europe are not frightened into their wits—why, they die every day and might avoid it, most of them, by

being inoculated. Mr. Sutton* would insure them at twelve-pence a head. He inoculates whole counties and it does not cause the least interruption to their business. They work in the fields, or go up to their middles in water as usual. It is silly to die of such an old-fashioned distemper!"

But there were occasional disasters, and in March, 1775, we find him writing:

"The Duke of Gloucester had lost his second daughter; both were inoculated, that he might carry them abroad. The youngest was very unhealthy, and died the next day after the disorder disappeared."

In the main, however, he was no doubt justified in what he says to Lady Ossory: ". . . inoculation now can scarce be called a hazard. It is sure as a cheat of winning, though a strange run of luck may once in two thousand times disappoint him".

EPIDEMICS.

The eighteenth century did not escape visitations of influenza, which seem to have recurred about every twenty years, for in March, 1743, Walpole writes to Mann:

"We have had loads of sunshine all the winter; and within these ten days nothing but snows, north-east winds and blue plagues. The last ships have brought over all your epidemic distempers: not a family in London has escaped under five or six ill: many people have been forced to hire new labourers. Guernier, the apothecary took two new apothecaries, and yet could not drug all his patients. It is a cold and fever. I had one of the worst and was blooded on Saturday and Sunday but it is quite gone: my father was blooded last night: his is but slight. The physicians say that there has been nothing like it since the year thirty three and then not so bad: in short, our army abroad would shudder to see what streams of blood have been let out! Nobody has died of it, but old Mr. Eyres of Chelsea through obstinacy of not bleeding; and his ancient Grace of York."

There seems to have been another, but milder, epidemic in 1762, for in June of that year he again writes:

"The King had one of the last of these strange and universally epidemic colds, which, however, have seldom been fatal: he had a violent cough and oppression on the breast which he concealed just as I had; but my life was of no consequence, and having no physicians in ordinary, I was cured in four nights by James's Powders, without bleeding. The King was blooded seven times and had three blisters."

The disease reappeared twenty years later, and once more we find him describing it to the faithful Mann (June, 1782):

"Since the naval triumph in the West Indies, I have had no public event to send you, nor anything else but journals of the epidemic disorder, which has been so universal and so little fatal, that a dozen names would comprise all I know who have escaped it, or died of it. The strangest part of it is, that, though of very short duration, it has left a weakness or lassitude, of which people find it very difficult to recover. One has had nothing to do but send messages of inquiry after all one's acquaintance; and yet, no servants to send on those messages. The theatres were shut up,

* Robert Sutton, an operator in Suffolk. He charged 5 guineas for each inoculation, and boasted that he had only had one accident out of the many hundreds of cases he had had under his care.

the Birth-day (4th June) empty, and the Ball to-night a solitude. My *coëcil* of gout confined me three weeks. I came hither to-day to air myself, though still very lame, and it is so cold that I am writing close to the fire."

There is a familiar ring about these descriptions which shows that influenza has not changed its essential character through the centuries.

In 1743 Walpole mentions that quarantine had been established for plague which had appeared first in Sicily, and two years later he writes to Mann *à propos* of the same subject, "Don't you remember a report of the plague's being in the City, and everybody went to the house where it was to see it". He then adds the comment, probably as true to-day as it was then, "Tis our characteristic to take dangers for sights and evils for curiosities".

The nature of some of the other epidemics mentioned in the *Letters* is not so easily identified.

What, for instance, was this:

"I have had nothing lately to tell you," he writes to Mann in March, 1748, "but illness and distempers; there is what they call a military fever raging, which has taken off a great many people. It was scarce known till within these seven or eight years, but apparently increases every spring and autumn. They don't know how to treat it but think they have discovered that bleeding is bad for it. The young Duke of Bridgewater is dead of it."

The following description (January, 1760), on the other hand, almost certainly refers to diphtheria:

"There is a horrid scene of distress in the family of Cavendish: the Duke's sister, Lady Besborough, died this morning of the same fever and sore throat of which she lost four children four years ago. It looks as if it was a plague fixed in the walls of their house: it broke out again among their servants, and carried off two, a year and a half after the children. About ten days ago Lord Besborough was seized with it, and escaped with difficulty: then the eldest daughter had it, though slightly: my lady, attending them, is dead of it in three days. It is the same sore throat which carried off Mr. Pelham's two only sons, two daughters, and a daughter of the Duke of Rutland, at once. The physicians, I think, don't know what to make of it."

NERVES.

Nerves seem to have been a pretty common trouble amongst fashionable people in Walpole's day, just as they are now. Thus he writes to Mann (May, 1780):

"I am grieved to hear you complain of your nerves, and know how to pity you. My own are so shattered that the sudden clapping of a door makes me tremble for some minutes. I should think sea-bathing might be of use to you. I know, though I have neglected it myself, that the sea air, even for four and twenty hours, is incredibly strengthening."

And towards the end of his life (1794) he complains to Lady Ossory of palpitations:

"I have of late years been subject to great palpitations, and they come more frequently and last longer. The wise in life and death insist they are only nervous: however I was seized with one on Saturday night, which continued so stormy that at four in the morning I was forced to send a man and horse to Twickenham for the apothecary, having such acute pain in my breast with it, that I concluded it the gout, and a warrant for me. Before he could arrive I had a slight vomiting, fell asleep for four hours—and am here still!"

ILLNESSES OF EMINENT PERSONS.

Being an inveterate gossip Walpole has naturally something to tell his correspondents about the illnesses of various prominent people of his time. In a letter of 1767 we find him expressing the rather rash opinion that "Lord Chatham's state is, too clearly, the gout flown up into his head", and again on the same subject:

"But there is a misfortune not so easily to be surmounted, the state of Lord Chatham's health, who now does not only not see the Ministers, but even does not receive letters. The world, on the report of the Opposition, believe his head disordered, and there is so far a kind of colour for this rumour, that he has lately taken Dr. Addington, a physician, in vogue, who originally was a mad doctor. The truth I believe is, that Addington, who is a kind of empiric, has forbidden his doing the least business, though he lies out of town, and everybody sees him pass in his coach along the streets. His case, I should think is a symptomatic fever, that ought to turn to gout; but Addington keeps him so low that the gout cannot make its effort. Lord Chatham's friends are much alarmed, and so they say is Addington himself; yet, what is strange, he calls in no other help."

The following refers to the alleged suicide of Lord Clive (1774):

"Lord H. has just been here and told me the manner of Lord Clive's death. Whatever had happened it had flung him into 'convulsions', to which he was very subject. Dr. Fothergill gave him, as he had done on like occasions, a dose of laudanum, but the pain in his bowels was so violent that he asked for a second dose. Dr. Fothergill said, if he took another he would be dead in an hour. The moment Fothergill was gone, he swallowed another, for another it seems stood by him, and he is dead."

This description of the onset of insanity in his nephew, Lord Orford, is curious:

"If I change this subject from my own person," he writes to Mann (February, 1773), "I must not go out of the family; I have a melancholy tale to tell you of another branch of it, my Lord Orford. He had a cutaneous eruption. By advice of his groom, he rubbed his body all over with an ointment of sulphur and hellebore. This poison struck in the disease. By as bad advice as his groom's, I mean his own, he took a violent antimonial medicine, which sweated him immoderately; and then he came to town, went to Court, took James's pills, without telling him of the quack drops, sat up late, and, though ordered by James to keep at home, returned into the country the next day. The cold struck all his nostrils and ails into his head, and the consequence is—insanity!"

Sometimes one is quite at a loss to identify the disease from his description of it. Take, for instance, his account of the last illness of his friend, Mr. Chute (May, 1776):

"Mr. Chute for these last two or three years was much broken by his long and repeated shocks of gout, yet was amazingly well, considering that he had suffered by it from twenty to seventy-three! Still, as he had never had it in his head or stomach, I never was alarmed till last summer, when he had a low lingering fever, and sickness and pain in his breast, with returns of an excessive palpitation at his heart, which formerly much alarmed me, but of which he had been free for some years. He got better and went to the Bath, which gave him the gout, and here turned quite well: so well, that, alarmed at our situation, he thought of drawing some money out of the Stocks and buying an annuity, saying, that he thought his life as good as any man's for five years. I am sure I thought so too. On Thursday last, being surprised at his not calling on me for three days, which was unusual, I went to him and was told that he was very ill. I found him in bed; he had so violent a pain in his breast that two days before he had sent for

Dr. Thomas, whom he had consulted in the summer, though of all men the most averse to physicians. Thomas had given him an hundred drops of laudanum and asafetida. Mr. Chute said, "It is not the gout: I have had my palpitation, and fear it is something of a polypus." Thus, perfectly reasonable, though with much more indifference than he who was all spirit and eagerness used to have, I attributed it to the laudanum, and indeed he desired me to leave him, as he was heavy, and wanted to sleep. He dozed all that evening, and had no return of pain. On Friday morning, still without pain. I saw him again. He had taken more asafetida, but no more laudanum; yet, when I said, I trusted the pain was gone, he said, "I do not know: the effects of the laudanum are not yet gone." I said I thought that impossible; that the pain would have surmounted the laudanum by that time, if the pain were not removed. I was coming hither on business, and charged his valet to send for me if the pain returned. On Saturday morning I rejoiced at not receiving even a letter by the post, and concluded all was well.

"This dream of satisfaction lasted all that day and Saturday night. I knew he would take no more laudanum, unless the pain returned, and that then I should be advertised. But, oh, unhappy! Yesterday, just as I had breakfasted, and was in the garden, I heard the bell at the gate ring, and wondered, as it was but ten o'clock, who would come to see me so early. I went to see, and met my valet-de-chambre, with a letter in his hand, who said, "Oh, Sir, Mr. Chute is dead!" In a word, he had continued quite easy till three that morning, when he said, 'Who is in the room?' His own valet replied, 'I, Sir', and, going to the bed, found him very ill, ran to call help, and returning as quickly as possible, saw him dead! It was certainly a polypus; his side immediately grew as black as ink."

What was a polypus? And why should the side immediately grow "black as ink"? We are left guessing.

PROMINENT MEDICAL MEN.

There are few mentions of prominent members of the medical profession in the *Letters*, as was to be expected, considering Walpole's prejudices, and such as there are have a rather malicious tone. He writes, for example, almost gleefully (July, 1750):

"Dr. Mead is undone; his fine collection is going to be sold; he owes about £25,000. All the world thought him immensely rich; but, besides the expenses of his collections, he kept a table for which alone he is said to have allowed £70 a week."

As a matter of fact, he was wrong in this, for Mead's great collection was not sold till after his death, when it realized a large sum.

In the following extract (November, 1780) the great John Hunter appears in the character of a politician:

"Dr. Hunter, that Scotch nightman, had the impudence to other day, to pour out at his Anatomic lecture a more outrageous Smelett than Smelett* himself, and imputed all our disgraces and ruin to the Opposition. Burke was present, and said he had heard of Political Arithmetic, but never before of Political Anatomy, yet for a Scot to dare thus in the heart of London, and be borne, is proof enough that the nation itself is lost beyond redemption."

A "nightman" presumably was a body-snatcher, and was just the sort of epithet that Walpole would apply to an eminent anatomist.

John Hunter's brother, William, also appears for a moment:

"Two mornings ago they might have seen me receive, first Dr. Hunter, and a moment after, Lady Craven—a man-midwife and so pretty a woman are very creditable; and yet, alas! he came to talk to me about Greek medals . . ."

* A favourite of George III.

And again Walpole must have his sneer of "man-midwife".

QUACKS.

The eighteenth century was the Golden Age of quackery, and more eminent quacks are mentioned in the *Letters* than eminent doctors. Not that Walpole believed in quacks; on the whole, he had as low an opinion of them as he had of medical men. "By quack," he says, "I mean impostor, not in opposition to but in common with physicians". His friends sometimes tried to persuade him to use quack remedies for his gout, but he would have none of them. He replies to Sir Horace Mann, who had recommended the treatment of Le Fevre, a French charlatan:

"Nov. 1770. I am much obliged to you for the detail of Le Fevre's medicine; but I am perfectly recovered without it, and strong in opinion against it. I am persuaded that he is a quack, and his nostrum dangerous. He has been here and carried off five thousand pounds, at a hundred pounds per patient!* You must know, I do not believe the gout to be curable. There must have been longer experience of this new remedy's effects before I would try it upon myself. I have known many nostrums stop every cranny into which the gout is used to crowd itself, and the consequence has always been an explosion. But I am not desparate, nor like the adage, *kill or cure*. But my great objection of all is, that the medicine begins with giving the gout. Thank it; I have not the disorder above once in two years, and it would be had economy to bring on what I may never live to have."

Another "gout doctor" of the day was Buzaglo, a Jew, who first attracted notice as an inventor of heating apparatus. He professed to cure gout by muscular exercise only, and advertised extensively. He is referred to in the following letter to Lady Ossory (December, 1777):

"Crawford is again confined with the gout. . . . He has heard that Taaffe has been cured by Buzaglo and sent for the former, who told him fairly that Buzaglo had removed his gout in four hours but said the operation would kill any man less strong."

Sir Robert Walpole, Horace's father (or alleged father), though he did not suffer from gout, was much afflicted in his later years with the kindred disorder, stone. He was treated for this by Mrs. Stephens's remedy, on which Horace makes the shrewd comment contained in this extract from a letter to Mann:

"My father has been extremely ill this week with his disorder; I think the physicians are more and more persuaded that it is the stone in his bladder. He is taking a preparation of Mrs. Stephens's Medicine, a receipt of one Dr. Jurin, which we began to fear was too violent for him: I made his doctor angry with me by arguing on this medicine which I never could comprehend. It is of so great violence, that it is to split a stone when it arrives at it, and yet it is to do no damage to all the tender intestines through which it must first pass."

Johanna Stephens, it may be remembered, was a lady who, in 1736, announced that she had discovered a cure for calculus, and two years later she offered the formula to the public for £5000. Astonishingly enough

* His medicine proved extremely noxious.—Walpole.

Parliament paid her this sum on the advice of a committee of which Stephen Hales, Cheselden and Hawkins were members (all of whom ought to have known better), and the "secret" was published in the *London Gazette* in 1739. The remedy proved to be chiefly composed of calcined egg-shells, snails, and a decoction of soap. She had indeed sold the country a "pup". It is said that Sir Robert Walpole, by using the "cure", had consumed in the course of several years at least 180 lb. of soap and 1200 gallons of lime-water! Yet he was attended by some of the best lithotomists of the day, and after his death three large stones were found in the bladder.

In 1789 Walpole writes: "Loutherbourg, the painter, is turned as inspired physician and has 3000 patients. His sovereign panacea is barley water. I believe it as efficacious as mesmerism." This Loutherbourg was a faith-healer. He was born in Germany in 1740, but came to England at the age of thirty and made some name as a painter, being elected a member of the Royal Academy in 1781. He was scene-painter to Garrick at Drury Lane and also produced several large marine pieces, one of which, depicting Howe's victory of June 1st, 1704, now hangs in Greenwich Hospital. Loutherbourg, in the later part of his life, settled at Chiswick and took up the study of the occult. He became convinced that he and his wife were gifted with the power of healing and for a time had a large number of adherents.

Another obscure quack named Thompson, about whom there is nothing to be discovered, figured in the tragedy of the death of Mr. Winington, "one of the finest men in England", described in a letter to Mann (1746):

"He was not quite so, extremely temperate and regular and of a constitution remarkably strong, hale and healthy. A little above a fortnight ago he was seized with an inflammatory rheumatism, a common and known case, dangerous, but scarce ever known to be fatal. He had a strong aversion to all physicians and lately had put himself into the hands of one Thompson, a quack, whose foundation of method could not be guessed, but by a general contradiction to all received practice. . . . This ignorant wretch soon made such progress in fatal absurdities, as purging, bleeding and starving him, and checking all perspiration that his friends Mr. Fox, and Sir Chas. Williams absolutely insisted on calling in a physician. Whom could they call but Dr. Broxholme an intimate old friend of Mr. Winington and to whose house he always went once a year. This doctor, grown paralytic and indolent, gave in to everything the quack advised. . . . At last, which at last came very speedily, they had reduced him to a total dissolution by a diabetes and a thrush; his friends all the time distracted for him, but hindered from assisting him, so far that the night before he died, Thompson gave him another purge though he could not get it all down. Mr. Fox by force brought Dr. Hulse, but it was too late . . ."

It is curious to think that in these days regular doctors were apparently quite ready to meet quacks in consultation and to adopt their treatment. This appears not merely from the above extract, but from other statements in the *Letters*. Professional etiquette

was apparently not so strict in this respect then as it is now.

Tar-water, although perhaps it can hardly be described as a quack remedy, was all the rage in the middle of the century, and Walpole, of course, mentions it in a letter to Mann (1744), telling him how popular it was:

"We are now mad about tar water on the publication of a book by Dr. Berkeley, Bishop of Cloyne. The book contains every subject from tar water to the Trinity: however, all the women read and understand it no more than they would if it were unintelligible. A man came into an apothecary's shop the other day, 'Do you sell tar-water?' 'Tar-water' replied the apothecary, 'Why, I sell nothing else.'"

But just as Walpole believed in one physician, Dr. James, and his powder, so he believed in one quack, the notorious Joshua Ward, and his "drops", and it is interesting to remember that the basis both of James's powder and Ward's drops was antimony. He did not hesitate to recommend Ward to his friends, as is shown by his writing to Mann (March, 1760):

"I wish you had given me any account of your headaches that I could show to Ward. He will no more comprehend nervous than the physicians do who use the word. Send me an exact description: if he can do you no good, at least it will be a satisfaction to me to have consulted him. . . ."

In another letter (April, 1761) he deprecates to Montagu that Ward was not called in to a serious case:

"Poor Lord Edgecombe is still alive, and may be so for some days; the physicians, who no longer ago than Friday evening persisted he had no dropsy in order to prevent his having Ward, on Monday last proposed that Ward should be called in . . . and at night they owned they thought the mortification begun—it is not clear it is yet. . . . What parts, genius, and agreeableness thrown away . . . and not permitted the chance of being saved by the villainy of physicians."

None the less, compared with other members of the eighteenth century society set, or even, it may be said, with the same class to-day, Walpole was singularly free from a belief in quackery.

OBITER DICTA.

Scattered throughout the *Letters* are some casual remarks and *obiter dicta* of medical interest. Here are some of them:

"I . . . cannot believe in the contagion of consumptions. . . . Were it catching, it would be still more common here than it is." [A wrong opinion, as time has shown.]

" . . . A cough, though a vexatious remedy, is a preservative of elderly persons, from exercising and clearing the heart and lungs. I know two or three who for years have had a constant cough in winter, and who have dangerous illnesses if it does not return in its season." [An interesting observation if correct.]

He writes to the Rev. W. Mason:

"You do not mention Gray's study of physic, of which he had read much, and I doubt to his hurt." [The poet is not the only layman, it is to be feared, who has studied physic "to his hurt".]

He says of his own constitution that it is "like grass that escapes the scythe by being low", that "bark

makes him sleep like opium", but "it is difficult to get it good" and that sleep is his great restorative—"no dormouse beats me". He sends his friend, Mr. George Montagu, a recipe for preserving the teeth which might be worth trying to-day; it is at least simpler and less expensive than some modern preventives of caries:

"Use a bit of alum twice or thrice in a week, no bigger than half your nail, till it has all dissolved in your mouth, and then spit it out. This has fortified my teeth that they are as strong as the pen of Junius. I learned it of Mrs. Grosvenor that had not a speck in her teeth to her death."

Finally we may take two sayings worthy of Dr. Johnson himself: "London agrees with me better than the country," and "Nothing is so troublesome as to talk of chronic complaints"—and yet he said he could talk gout by the hour!

Even allowing for Walpole's prejudices, the impression of eighteenth century medicine conveyed by the *Letters* is a melancholy one. What with the absence of anaesthetics, antiseptics, morphia and skilled nursing, and with pompous and ignorant physicians, bleeding, blistering, purging and prescribing gallons of nauseous drugs, every illness must have been a nightmare. No wonder the arch-cynic of the century stigmatized the art of medicine as being like the art of war—"both murderous and conjectural".

ROBERT HUTCHINSON.

AN UNUSUAL ŒSOPHAGEAL NEOPLASM.

THE incidence of carcinoma of the œsophagus in men is very much higher than in women; but the post-cricoid type of growth is said to occur more commonly in the female sex. The figures of Logan Turner (1) bear out this statement, and it is noteworthy that the occurrence of carcinoma of the upper end of the œsophagus has been described more commonly among females in Scotland than elsewhere. This has been connected with the habit, prevalent among them, of drinking hot tea very frequently. Similarly in China the eating of hot rice by the women has been adduced as a partial explanation of the high incidence of post-cricoid carcinoma in that country.

It is interesting, then, that the subject of this report should be a Scotch lady, æt. 53, in domestic service, who first came to the Hospital on January 6th, 1934, complaining of a swelling in the neck. This she had noticed for the first time six weeks previously and it had rapidly increased in size and been accompanied by progressive difficulty and pain in swallowing. Eventually fluids only could be taken and there was marked anorexia, with a loss in weight of about one stone in the six weeks. There had been no alteration in the

patient's voice and she had not suffered from cough or shortness of breath.

On examination of the patient, who looked emaciated, there was seen to be a swelling in the region of the thyroid gland, which moved on deglutition (Fig. 1). It seemed to be more prominent on the left than the right side, and on palpation was found to be firm and uniformly smooth. The larynx was displaced forwards and slightly to the right, and the trachea could easily be felt subcutaneously just to the right of the mid-line in the notch of the manubrium sterni. The œsophagus, as seen by the passage of fluid on swallowing, was apparently displaced forwards and slightly to the left,



FIG. 1.

but the thyroid gland was not clearly definable. Neither the right lobe nor the isthmus could be felt, and the tumour described appeared to occupy the position of the left lobe of the gland. There were no signs of thyrotoxaemia, apart from the loss in weight, and no enlarged glands in the neck or supraclavicular region. A tentative diagnosis was made of carcinoma of the thyroid.

On admission to the Hospital four days later the patient was X-rayed after being given a barium emulsion, and the result showed that the tumour was involving the œsophagus as well as displacing it forwards. The dysphagia was by this time extreme and only small quantities of fluid could be taken in the course of the day, which were supplemented by glucose and saline *per rectum*.

An operation for exploration of the tumour was performed by Mr. Keynes on January 12th through a collar incision. The thyroid gland was found to be normal

and the larynx displaced to the right; behind the left lobe of the thyroid gland was an oval, well-defined tumour, fixed only to surrounding structures posteriorly, where it appeared to be attached to prevertebral muscles. Its relation to the œsophagus at its lower end was difficult to determine, as it extended downwards into the superior mediastinum; and an endotracheal catheter, passed into the mouth, failed to pass an obvious constriction at the pharyngo-œsophageal junction and was, therefore, of no assistance in delineating the relation of the tumour to the œsophagus above. On further dissection below it was then found that the tumour was continuous with the wall of the œsophagus,

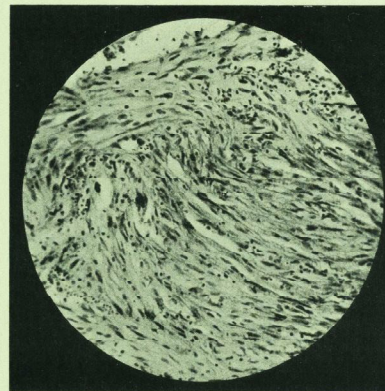


FIG. 2.

of which it therefore represented a proliferating growth, involving the whole circumference. Bearing in mind the possibility of later cervical œsophagectomy, the mediastinum was accordingly plugged with gauze and a piece of the tumour taken for section. A gastrostomy was then done, and for the next six days, until her death, the patient was fed entirely by this method. Death occurred eight days after admission, and was due to mediastinitis and pneumonia.

The section of the tumour seen by Prof. Kettle (2) showed the structure of a spindle-celled sarcoma (Fig. 2), and some doubt was felt as to its nature. In some areas it had the appearance of an anaplastic carcinoma and in others it looked sarcomatous.

Herxheimer (3) has reported a case in which a true mixed tumour occurred in the œsophagus, and of 671 cases of œsophageal new growth cited by Chevalier Jackson (4), only 4 were found to be sarcomatous. Of

these, 2 had the appearance of lymphosarcoma and 2 of round celled sarcoma. Rolleston (5), however, quotes the occurrence of a spindle-celled type of growth in the œsophagus, and Corner and Fairbank (6) found 3 in a series of 14 cases of œsophageal sarcoma. The growth appears to begin in the submucous tissue and usually completely surrounds the œsophagus. Ulceration with perforation and subsequent mediastinitis is frequent and occurs more often than in carcinoma.

As no post-mortem examination was allowed on the patient described, the presence or absence of metastases could not be recorded. As in sarcomata elsewhere it is, however, usual to find them in the majority of cases.

My thanks are due to Mr. Keynes for permission to publish the case.

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G. BLACKBURN.

A LEGACY TO ST. BARTHOLOMEW'S HOSPITAL FROM A GRATEFUL PATIENT IN THE YEAR 1580.

NUNCUPATIVE wills have had a fascination for me ever since reading the account of the Lady Rohesia in the *Ingoldsby Legends* as a lad. It occurred to me that St. Bartholomew's men might be interested in the nuncupative will of Jerome Hilton, dated March 5th, 1580.

In the *Act Book* Hilton is called schoolmaster. The transcript of the will is as follows:

"The will of Jerome Hilton, 5. Marche 1580, being sicke in the hospitall house of Myle Ende and beinge in perfecte memorie did speake and declare before his

decease his laste wylle and testament nuncupatyve under these forme of worddes followinge or the like in effecte. viz. That whereas he had owinge him by Mr. Carr the minister . . . £5, Mr. Blithemann £5, (blank) clothworker £3 13s. and in ready moneye in his owne custodye £3 . . . for that he hadde Receaved suche benefytte at the handes of the Maisters and Governours of Saincte Bartholomew's he was contented to geve and did geve unto the Mr. and Govnors unto the use of the poore of the same hospitall of Saincte Bartholomewc, the whole summe of £16. with all other his gooddes and debtes, as there might be gottenne beinge sorye that he had no more to geve unto them wch wordes weare spoken by Jerome Hilton in the presence and hearinge of John Bacon, Katherine Bacon, Thomas Browne, Thomas Missinden, Richard Harisonne with others."

This will (P.C.C. Darcy, 10) was proved March 23rd, 1580/81.

With regard to the testator, in Foster's *Alumni Oxonienses* I find that a Jerome Hilton supplicated for his B.A. on December 7th, 1571. It is probable that this entry refers to our man.

The hospital at Myle Ende was one of the lazar houses in connection with St. Bartholomew's, about which Sir Norman Moore has written in the second volume of his history.

A person who made a nuncupative will in medieval times was usually at death's door. The word is derived from the Latin *nuncupo*, I declare. It was a verbal disposition of one's goods made in the presence of witnesses, and in England goes back to Anglo-Saxon times.

Reading between the lines one would assume that Hilton had been under hospital treatment for some considerable time and it is pleasant to know that he was a grateful patient. He may have died from some acute intercurrent disease, and it seems idle to speculate at the present time as to the condition for which he received treatment.

I am indebted to Mr. J. Harvey Bloom for the transcript.

R. R. JAMES.

ACKNOWLEDGMENTS.

The British Journal of Nursing—The Nursing Times—Charing Cross Hospital Gazette—Guy's Hospital Gazette—St. George's Hospital Gazette—Middlesex Hospital Journal—Queen's Medical Magazine—St. Mary's Hospital Gazette—St. Thomas's Hospital Gazette—The Student—University College Hospital Magazine—King's College Hospital Gazette—Clinical Journal—East African Medical Journal—The General Practitioner—The Hospital—Bulletin et Mémoires de la Société Médicale de Paris—L'Echo Médical du Nord—The Medical Forum—The Medical Press and Circular—Medical Times and Long Island Medical Journal—Post-Graduate Medical Journal—Reale Società Italiana D'Igiene—Revue Belge des Sciences Médicales—Archives Hospitalières.

MEMOIRS OF A CAMP FOLLOWER.*

AT a time when the world is growing hysterical at the thought of another war, and our bookshelves are becoming overcrowded with grotesque accounts of the last, Dr. Philip Gosse has published a much-needed sedative in the form of his *Memoirs of a Camp Follower*. Here is no lengthy tome to bring back agonizing reminiscences of the mutilations of man and his beloved countryside, but, as Dr. Gosse deftly says in his preface, the book might well be called a "solace of birds"; by now "the mangled corpse is forgotten, but the warbler with its nest and eggs is remembered".

Let us go back once again to that perfect September day in 1915 and set out on "The Great Adventure" with the Camp Follower (M.O. to the 69th Field Ambulance). Stationed at the advanced dressing station at Grisport (Greasepot) we are first introduced to our host, sulky and morose, who owned the cottage where we were billeted and was popularly believed to be a German spy. The daily life of a M.O. in Flanders consisted of quiet periods with occasional bursts of work, and it was now that the opportunity became apparent for collecting and studying the small mammals of the district. How fortunate it was that the Natural History Museum was in need of specimens from this part of Europe. Many hours were spent and risks overcome till the first batch of the collection was skinned and duly despatched to the British Museum.

We then spend our first Xmas at the dressing station and find that a Flanders Xmas dinner is a feast for a king, while the concert which followed brought back memories of the ward shows at Bart's, both in their originality and success. It was in the following February that we moved south with the Division to the neighbourhood of Aire, and a few weeks later to Bois Mont, where at last we enter the paradise of birds. The inhabitants—white throats, black-caps, warblers, swallows and thrushes—were at the time busy building their nests, and it was here that we heard the enchanting sound of our avian pacifist, the turtle-dove, while a few days later we went on an unsuccessful bird-hunting expedition with a Divisional General and his *aide-de-camp*.

Again we must be on the move, and in the garden of the Chateau at Coupigny-Hersin we enter another aviary, where we can lie on the cool May evenings and listen to the "ventriquoist rehearsal" of an itinerant warbler, and attend the ornithological garden-party given in honour of General Babington's visit to the

* *Memoirs of a Camp Follower*, by Philip Gosse. Longmans, 10s. 6d.

special hospital. Alas! The peace is suddenly broken by the terrifying shriek of a huge approaching shell, and our Garden of Eden is soon ravished by several of these monstrous horrors.

At Fosse 10 work is heavy, and it is not till we reach the front line trenches at Givenchy that we are introduced to that feline heroine, "The Landlady". We eagerly watch her, seated on the parapet of the fire trench, performing every minutiae of her toilet in full view of two vast contending armies, and then she disappears into No-man's Land till she feels inclined to return at dawn thirsty and ready for happy slumber. What a care-free spirit amid so much tension!

On the Somme our nerves became wrecked and our spirits lowered by continual noise and danger; it is not till we are near Monfièrs, under the safe roof of Monsieur et Madame Fosse, that we learn how many friends and even relatives one may have in a foreign country.

Although Hamelin town is in Germany, it was to the Director of Medical Services to the Second Army at Hazebrouck that the Pied Piper turned his attentions at a time when the trenches were becoming overrun with rats. No bag of gold or promise of promotion was offered as prize to the would-be rat catcher, so the riddance was undertaken by prophylaxis rather than the regimental drum and fife band. The rat campaign was later moved from Vieuxbec to the mobile laboratory at Remy Siding; it was there that the "scare" took place. A rat was sent from Reninghelst whose axillary glands and groins suggested bubonic plague; after verifying the cultures the alarm was raised, but it cost the country £5000 in unwanted Haffkin's plague vaccine.

Late in September, 1917 the good news arrived to say farewell to the bloody Salient, and "proceed" to England and then to the East. Here at last was the realization of a life's dream. India! What a land of ecstasy for a naturalist, in spite of dysentery and malaria. Poona, Khandala and the Nilgiri hills were happy hunting-grounds for mammals, especially for a very special kind of rope dancer (*Funambulus Gossei*), and an exceptional thick-tailed wrinkle-lip bat (*Tadarida Gossei*). But all good things have to end sometime, and in spite of the lethargy of Poona the news of the Armistice did eventually reach this outlying portion of the Empire.

The dangers of the war were yet to be surpassed, as it was at Salonika, on the journey home, that the miraculous escape of the Camp Follower took place. Let us hear his own confession: "During one of the Christmas parties a nurse took me for a little stroll to admire Mount Olympus by moonlight. Outside the building we discovered there was no moon, but the heavens were

aglow with twinkling stars which we agreed did just as well, if not better. Whilst we stood close together, much moved by the marvellous spectacle, the shrill blast of a steam whistle made us leap aside and a railway engine rushed past, missing us both by inches. We must have been so engrossed studying the heavens that we had not noticed we were standing on a railway line."

"Oh, I've had such a curious dream," said Alice, and as she sat on with closed eyes and half believed herself in Wonderland, she knew that she had but to open them again and all would change to dull reality. With these same feelings we land back once again with the Camp Follower and his twenty-two remaining boxes of luggage at Southampton, but Providence was kind throughout the Great War, and a few days later the two missing boxes followed us to London.

STUDENTS' UNION.

STUDENTS' UNION.

The Annual General Meeting was held on Thursday, March 15th, 1934. The following were elected officers for the year 1934-1935:

President: Dr. H. E. G. Boyle.
Vice-President: S. E. Furber.
Treasurer: Dr. Wilfred Shaw and Mr. Patterson Ross.
Secretary: J. G. Youngman.
Council: Constituency A—K. A. Latter, R. Mundy, J. D. Wilson, J. R. Kingdon, R. G. Gibson.
Constituency B—E. Hambley, R. Hanbury Webber.
Constituency C—Mr. S. J. Hadfield.

SECRETARY'S ANNUAL REPORT, 1933-1934.

The year has been an eventful one in the life of the Students' Union in the acquiring of the Merchant Taylors' School by the Medical College, which has provided a ground, five courts, gymnasium, and shooting range for the use of the Students' Union. By the kindness of the College, the Union pays no rent or rates for the amenities, but has undertaken to keep them in good condition. The ground and gymnasium have been invaluable for the purposes of training, and in the gymnasium a boxing ring has been erected and the boxing club meetings are held there. The five courts were four in number, but two of them have been converted into squash courts, and it is hoped that a squash club will be formed in the near future.

H.R.H. The Prince of Wales visited the site in December and showed great interest in the activities of the Union, and expressed his great pleasure at the welcome which was extended to him by the students.

The Annual Dance was held at Grosvenor House in November, at which there was a record attendance of over four hundred people. The receipts for the dance showed a profit of £46, £40 of which were handed over to the Dean for his Appeal.

Another dance organized by the pre-clinical students was held at the Merchant Taylors' in January, in aid of the Medical College Appeal, which was a great success, and yielded £50 for the Appeal.

The students' contribution to the Appeal now amounts to approximately £600; this figure is good, but the number of students contributing is only in the neighbourhood of 300—which seems hardly representative in a Union of this size.

As usual, considerable success has attended the activities of the Clubs of the Union:

THE RUGBY FOOTBALL CLUB.

This season the membership has been increased considerably, the Club being able to field seven teams on most Saturdays, as well as a

number of mid-week sides, the one regret being that in a club of such large membership only one pitch is available for play, necessitating the junior teams having to play away from home, with consequent difficulty in arranging fixtures.

The results are a little disappointing after the very successful year last year, the 1st XV being runners-up in the Hospital Cup Tournament. Results up to date are as follows:

	Played.	Won.	Drawn.	Lost.
1st XV	27	10	3	14
"A" XV	23	8	..	15
Ex "A" XV	24	13	..	11
"B" XV	17	8	1	8
Ex "B" XV	9	5	..	4
"C" XV	12	7	..	5
Ex "C" XV	8	5	..	3

In the Hospital Cup Competition the 1st XV reached the semi-final, in which they were narrowly beaten by St. Thomas's Hospital—11 pts. to 9 pts.—after a most exciting game. The "A" XV have reached the semi-final of the Junior Cup.

In April an inter-firm 7-a-side competition was held at Winchmore Hill, followed by a dance in the evening. The Light Blue firm were worthy winners of the competition. The dance, which was an unqualified success, was held at No. 16, Bruton Street. A similar competition and dance is being held on April 14th this year.

THE CRICKET CLUB.

The Cricket Club has had a successful season, the results being as follows:

	Played.	Won.	Drawn.	Lost.
1st XI	19	9	4	6
2nd XI	15	5	3	4

For the third successive season both teams reached the final of the Hospital Cup. The 1st XI were defeated by St. Thomas's in a close and exciting game by one wicket, and the 2nd XI won their match, thereby winning the Junior Cup for the third successive season.

Three centuries were scored—one in the 1st XI by A. Boney, two in the 2nd XI by G. Wedd and A. Wheeler.

In the final against St. Thomas's Wedd scored 181 in two innings, and also took 10 wickets for 188 runs.

ASSOCIATION FOOTBALL CLUB.

The Club has had a more successful season this year. Results are as follows:

	Played.	Won.	Drawn.	Lost.
1st XI	18	8	2	8
2nd XI	17	5	2	10
3rd XI	15	6	1	6

In the Hospitals Cup Competition both 1st and 2nd XIs have so far reached the final round, and are due to meet Guy's Hospital. Since the writing of this report both teams have won the Inter-Hospitals competitions.

THE HOCKEY CLUB.

With a slightly larger membership than last year it has been possible to field three teams on most Saturdays. The season started badly, but has since improved. Results:

	Played.	Won.	Drawn.	Lost.
1st XI	21	8	4	9
2nd XI	18	4	1	13
3rd XI	4	4

In the Hospital Cup Competition the 1st XI has reached the semi-final and the 2nd XI the final. Both teams have reasonable chances of winning.

ATHLETIC CLUB.

The Athletic Club succeeded in winning the Inter-Hospital Championship Shield after having been runners-up for the past six years with a score of 62 points—a high score, and indicative of the all-round strength of the Hospital team. Four champions were provided by the team, and C. P. C. Reilly was awarded the "Princess Marie Louise" Cup for the best individual performance in breaking the 440 yards hurdle record, and also the "D.M.A." Cup for the best all-round athlete.

The Club was fortunate in being able to arrange several fixtures over and above those usually held, namely, the Annual Sports and Inter-Hospitals Competitions. These were against Monckton Combe School, Emmanuel, Queens' and Caius Colleges, Cambridge, Southgate and Lensbury Harriers, Barclays Bank and St. Thomas's Hospital; a comfortable victory was scored on each occasion.

The Annual Sports were held at Winchmore Hill, and no less than five Hospital records were broken. The amenities for training at the Merchant Taylors' have proved invaluable, and it is hoped that this year will prove even more successful than last for the Athletic Club.

THE BOXING CLUB.

There has been a considerable increase of members this year and much new talent has been discovered. The new Gymnasium has proved invaluable for training purposes. A fixture with University College was held on January 19th, resulting in a win for the Club by 5 bouts to 2. Six members of the Club have represented the United Hospitals team in the matches against Oxford University and London University. Matt Wells continues to be invaluable as trainer and instructor to the Club. In the Inter-Hospitals Competitions the Club scored a record win, scoring 34 points, with St. Mary's second with 17 points. Six members of the Club won their respective weights.

THE SAILING CLUB.

The Sailing Club had a most successful year, winning no less than three cups presented for inter-hospital sailing.

The Harvey Cup, presented for races held on Saturdays other than Bank Holidays, and in Burnham Week, was won easily by 79 points to 28 scored by St. Mary's, the runners-up.

The Bourne Trophy, for races held on Bank Holidays and in Burnham Week, was won by 1 point.

The Wilson Cup for single-handed racing was won by W. H. Cartwright.

In the Sherran Cup, W. H. Cartwright and R. G. Macfarlane sailed in the first and second rounds of the first race, and G. C. Brentnall and K. F. Stephens in the second race. Both races were won.

During the past year the United Hospitals Sailing Club have managed to acquire the site for a club-house of its own. This is now in the hands of the builders, and is expected to be ready for the use and benefit of members early next season.

THE RIFLE CLUB.

The season on the open range, though producing no team trophies, was highly satisfactory. Two members represented the United Hospitals Astor Cup Team, and three gained prizes at the United Hospitals Prize Meeting.

On the miniature range the Club has had a very successful season: of 41 matches shot, no less than 32 have been won. So far last year's unbeaten record in inter-hospital matches has been maintained. In the Engineers' Cup League, containing eight teams representing hospitals and colleges in the London area, the Club is at the head—a position it has occupied since the beginning of the season. In the City of London Rifle League Competition, the "A" team is third in a division of 11. Keen competition has been shown in the Hospital cups, and a new knock-out tournament involving rapid fire at clay discs is about to commence.

GOLF CLUB.

The Golf Club had quite a successful year, though of seven matches played, only three were won, but the Club managed to reach the final of the Inter-Hospitals Competition by defeating King's, St. Mary's and the London Hospital, but were narrowly beaten in the final by St. Thomas's Hospital.

In the Staff v. Students Match the Staff won by 24 points to 64, and Dr. Wroth and G. D. Wedd won the Staff and Students' Foursomes.

The Girling Ball Cup was won by R. B. Halford, and the Hospital Cup by R. H. Purnell.

THE BOAT CLUB.

Unfortunately it was impossible to raise an eight during the year, but it is hoped that this year the Club will be able to do so.

THE AMATEUR DRAMATIC SOCIETY.

The Amateur Dramatic Society celebrated its fiftieth Anniversary. In January the Society presented *Bird in Hand*, by John Drinkwater, which was produced by Stanhope Furber, preceded by a one-act play by Saki called *The Death Trap*, produced by Eric Jewesbury. The Hospital Musical Society provided an excellent orchestra. The performances were well received by full houses.

LAWN TENNIS CLUB.

The Lawn Tennis Club had an enjoyable and successful season. Results:

	Played.	Won.	Lost.
1st VI	13	9	4
2nd VI	6	4	2

Many matches had to be scratched owing to bad weather. In the Inter-Hospitals Competition the 1st VI were beaten in the final by St. Thomas's, and in the junior competition the 2nd VI were beaten in the 2nd round by St. George's.

W. K. Frewen won the Hospital singles tournament.

ABERNETHIAN SOCIETY.

The Abernethian Society has had a very successful year, and the lectures and clinical evenings arranged for the Society have been well attended, particularly in the latter part of the year.

The opening address of the Summer Session was given by Prof. Burgess, who dealt in a refreshing manner with the historical aspect of "Cutting for the Stone".

On June 29th Dr. Cahill issued a running commentary to his extremely interesting cinematograph films of the culture of living tissues *in vitro*.

The Inaugural Address of the Michaelmas Session was delivered on October 19th, 1933, by Sir Henry Gauvain, his subject being "Twenty-five Years at Treloar's"—a review of the strides made in the physical treatment of tuberculous infections, and on February 30th an extremely interesting informal discussion on "Osteopathy" between Mr. Macdonald and Mr. Elmisle took place before a very large audience.

The final meeting of the year was given by John Drinkwater, who read some of his poems to a large and enthusiastic audience.

Two clinical evenings have been held, but the Secretaries feel that this number should be increased during the coming year, as they have been well attended, and considerable interest has been shown.

FIVES CLUB.

The Fives Club has not been as successful as it was hoped.

Results: played 12, won 4, lost 8.

All matches were played in the court in the Hospital.

The Club acquired four courts at the Merchant Taylors', two of which have been converted into squash courts by the Students' Union. This step has been amply justified, as the squash courts are in almost constant use.

The singles and doubles competition in fives is still being played.

THE SWIMMING CLUB.

The Swimming Club had a most successful season, winning most of their matches.

In the Inter-Hospitals Competition all three Challenge Trophies were won.

In the six-a-side relay the Club was third.

The Diving Cup was won by the Club owing to the excellence of the diving of C. A. Brockbank.

The water polo cup was won for the fifth year running.

Finally, Gentlemen, we wish the Students' Union every success in the coming year, and beg to remain,

Your obedient servants,
STANHOPE E. FURBER,
J. G. YOUNGMAN.

ABERNETHIAN SOCIETY.

A Sessional Meeting was held at 8.30 p.m. on February 1st, 1934, in the Medical and Surgical Theatre, before a large audience.

The minutes of the previous meeting were read and confirmed, and the President, Mr. Leishman, then introduced the guest of the evening, Mr. John Drinkwater, to the Society, referring to the

extremely successful production of *Bird in Hand* by the Hospital Amateur Dramatic Society during the previous month, and to the amazingly wide range of subjects of which Mr. Drinkwater showed himself a master.

Mr. Drinkwater, before he turned to his latest volume of poems—*Summer Harvest*—dealt briefly with a few of the many poets who had also been of the medical profession. Taking as examples Hale White, Keats, and Robert Bridges, he put forward the view that the many and varied personal contacts and experiences realized and undergone by doctors provided a valuable field for the exercise of a poetic temperament.

He expressed his scorn, however, for those "canting dilettantes" who make a mere pretence of poetry and art, without applying themselves assiduously to the realization and practice of the basic principles of such arts.

He then turned to *Summer Harvest*, from which he read extracts, introducing the different sections of the book with vivid descriptions of circumstances under which the works were produced, and the experiences that inspired the poems. Commencing with "Egyptian Idylls", of which he read "Nile Fisherman", "Egyptian Camel Corps", and "Fellabeen", he reminded us that that country was a wonderful historical background, "where one is ever reminded of the immemorial continuity of Life".

Mr. Drinkwater then passed to "American Vignettes", and indicated how moved he was with the raw, yet hospitable freshness of this young country, "where one is always coming up against things and situations that are now epigrams". Of this section he read "The Overcoat" and the delightful "Uncle Wat".

He followed with a few extracts from "Diversions", "Men and Occasions", and closed with "Water Meadows", "Amaranth", and "Summer's End" from "Green Acres", a poem especially appreciated by the enthusiastic audience being "Note to Walter de la Mare", from the section "Penelope's Poems".

The vote of thanks was proposed by LORD HORDER in his inimitable manner, who informed the Society that he had had the honour of saying good-night that evening to Penelope Anne who was the origin of the "Note to Walter de la Mare"; Mr. BLACKBURN ably seconded the vote of thanks.

Mr. Drinkwater replied briefly, bringing to an end a highly successful and refreshing evening.

A. H. HUNT } Hon. Secs.
A. INNES }

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEWS MEN.

- ADAMSON, H. G., M.D., F.R.C.P. "The Real Position of Willian and Bateman's Teaching in Regard to Eczema." *British Journal of Dermatology and Syphilis*, December, 1933.
- ADDISON, The Right Hon. CHRISTOPHER, P.C., M.D., F.R.C.S. *Four and a Half Years*. Vol. 1. London: Hutchinson & Co., 1934.
- BERTWISTLE, A. P., M.B., Ch.B., F.R.C.S.(Edin.). "Cavernous Navi." *Lancet*, January 6th, 1934.
- BOYLE, H. E. G., O.B.E., M.R.C.S., L.R.C.P. "Nitrous Oxide: History and Development." *British Medical Journal*, January 27th, 1934.
- BRAIMBRIDGE, C.V., F.R.C.S.(Edin.). "Rupture of the Duodenum." *British Medical Journal*, February 17th, 1934.
- BURROWS, H. JACKSON, M.D., F.R.C.S. "Two Cases of Ossification in the Internal Semilunar Cartilage." *British Journal of Surgery*, January, 1934.
- BURROWS, HAROLD, C.B.E., M.D., F.R.C.S. "The Occurrence of Scrotal Hernia in Mice under Treatment with Estrin." *British Journal of Surgery*, January, 1934.
- CAMMIDGE, P. J., M.D. "The Prognosis of Symptomatic Glycururia." *British Medical Journal*, December 30th, 1933.
- "Hereditas as a Factor in the Etiology of Diabetes Mellitus." *Lancet*, February 24th, 1934.
- COCHRANE, R. G., M.D., M.R.C.P., D.T.M.&H. "Leprosy in India and Ceylon." *Leprosy Review*, January, 1934.
- CORSI, H., M.B., F.R.C.S. "Dermatitis Bullosa Pratiensis Striata." *British Journal of Dermatology and Syphilis*, December, 1933.
- CUMBERBATCH, ELKIN, M.A., B.M., B.Ch., D.M.R.E., F.R.C.P. "The Action and Uses of the Diathermic Current." *Practitioner*, February, 1934.

- DAVIES, J. H. TWISTON, M.B. "Common Growths of the Skin and their Treatment." *Medical Forum*, October-December, 1933.
- DONALDSON, MALCOLM, M.B., F.R.C.S. *Radiotherapy in the Diseases of Women*. London: Hodder & Stoughton, 1934.
- DOWNER, R. L. E., M.D. "Sibacote Inversion of the Uterus." *British Medical Journal*, February 24th, 1934.
- DUNDAS-GRANT, SIR JAMES, K.B.E., M.D., F.R.C.S. "Diet in the Treatment of Lupus." *Practitioner*, January, 1934.
- GASK, GEORGE E., C.M.G., D.S.O., F.R.C.S., and ROSS, J. PATERSON, M.S., F.R.C.S. *The Surgery of the Sympathetic Nervous System*. London: Baillière, Tindall & Cox, 1934.
- GAUVAIN, SIR HENRY J., M.A., M.D., M.Chir., F.R.C.S. "Reflections on Sun Treatment: The Theory of Varying Stimuli and Varying Response." *Practitioner*, February, 1934.
- HALL, ARTHUR J., M.A., M.D., D.Sc.(Hon.), F.R.C.P. "Bodily Diseases in Mental Disorders." *British Medical Journal*, January 27th, 1934.
- HAMILL, J. M., O.B.E., M.D., D.Sc. "Milk." *Lancet*, December 30th, 1933.
- KEYNES, GEOFFREY, M.A., M.D., F.R.C.S. "The Radium Treatment of Primary Carcinoma of the Breast." *The Canadian Medical Association Journal*, January, 1934.
- KLABER, ROBERT, M.D., M.R.C.P. "Primary Cutaneous Actinomycosis: With a Note on the *Bacillus actinomycetem comitans*." *British Journal of Dermatology and Syphilis*, January, 1934.
- MAXWELL, JAMES, M.D., M.R.C.P. "A Further Note on the Plasma Cholesterol in Nephritis." *Quarterly Journal of Medicine*, January, 1934.
- NELSON, H. P., M.D., F.R.C.S. "Collapse Therapy in Bronchiec-tasis." *British Medical Journal*, January 13th, 1934.
- NICOL, W. D., M.B., B.S., M.R.C.P., D.P.M. "The Relation of Syphilis to Mental Disorder and the Treatment of G.P.I. by Malaria." *British Journal of Venereal Diseases*, October-December, 1933.
- NIXON, J. A., C.M.G., M.D., F.R.C.P. "Adequate Diets in Diabetes Mellitus: A New Approach." *Practitioner*, January, 1934.
- "Food Values and their Practical Application to Diabetics." *British Medical Journal*, January 6th, 1934.
- PAYNE, REGINALD J., M.B., B.S., F.R.C.S. "Infra-Red Photography of the Superficial Venous System." *Lancet*, February 3rd, 1934.
- POWER, SIR D'ARCY, K.B.E., F.R.C.S. "Some Early Surgical Cases. II: The Edwin Smith Papyrus." *British Journal of Surgery*, January, 1934.
- PREISKEL, I. M.B., F.R.C.S. (H. L. ATTWATER, M.Chir., F.R.C.S., and I. P.). "Excision of a Traumatic Stricture." *Lancet*, December 23rd, 1933.
- PYBUS, F. C., M.S., F.R.C.S. "A Case of Gas-cysts of the Intestine." *British Journal of Surgery*, January, 1934.
- RAY, P. N., F.R.C.S. "Spontaneous Dislocation of the Hip in Childhood." *British Journal of Surgery*, January, 1934.
- ROBINSON, C. A., B.A., M.B., D.M.K.E. "Diathermy in Gynaecology." *Practitioner*, February, 1934.
- ROLLESTON, SIR HUMPHRY, Bart., G.C.V.O., K.C.B., M.D., F.R.C.P. "Methods of Physical Treatment: Introduction." *Practitioner*, February, 1934.
- ROSS, J. PATERSON, M.S., F.R.C.S. See Gask and Ross.
- "Hypodermolitis." *British Medical Journal*, February 10th, 1934.
- SHAW, WILFRED, M.D., F.R.C.S., F.C.O.G. "Ovulation and Menstruation." *British Medical Journal*, January 6th, 1934.
- SLOT, GERALD M., M.D., M.R.C.P., D.P.H. "Treatment of Arthritis and Rheumatism with Gold." *Lancet*, January 13th, 1934.
- SPACKMAN, W. C., Lt.-Col. I.M.S., M.B., B.S., F.R.C.S.(Edin.). "A Case of Ovarian Pregnancy." *British Medical Journal*, February 10th, 1934.
- STRETTON, J. W., F.R.C.S. "Catgut Tube Forceps." *Lancet*, February 24th, 1934.
- VINES, H. W. C., M.A., M.D. (L. R. BOOSTER, O.B.E., D.M., M.Ch. (Oxon.), F.R.C.S.(Eng.), and H. W. C. V.). *The Adrenal Cortex: A Surgical and Pathological Study*. London: H. K. Lewis & Co., 1933.
- WEBER, F. PARKES, M.D., F.R.C.P. "Familial Asthenia (Paralytic) Type of Thorax with Congenital Ectopia of Lenses." *Lancet*, December 30th, 1933.
- WILSON, W. ETHERINGTON, F.R.C.S. "Intra-thecal Nerve Root Block." *British Journal of Anaesthesia*, January, 1934.

CHANGES OF ADDRESS.

- ALDRIDGE, J. S., Juba, Sudan.
- BENISON, R. L., 5, Harrington Square, N.W. 1.
- BRAIMBRIDGE, C. VINEY, Coolgardie, Aldwick Road, Bognor Regis.
- CORFE, F. K., 136, High Street, Brentwood, Essex. (Tel. Brentwood 231.)
- CUSACK, M. K., Grianán, Dungarvan, Co. Waterford.
- FEAR, R. G., The Donhead Surgery, The Old Mill, Donhead, near Shaftesbury, Dorset.
- MORE NISBETT, Surg.-Lt. J. G., R.N., H.M.S. "Courageous", c/o C.P.O., London.
- POWELL, J. C., 11, Upper Wimpole Street, W. 1. (Tel. Welbeck 2502.)
- SMITH, Surg.-Capt. W. C. B., R.N., St. Gabriel's, Denville, Havant, Hants.
- STORER, R. V., 9a, Cavendish Square, W. 1.

APPOINTMENT.

WEST, R. G. R., M.D., M.R.C.P., appointed University Demonstrator of Pharmacology, Oxford.

BIRTHS.

- ELLIS.—On February 25th, 1934, at Bourton, Dorset, to Mary, wife of George E. Ellis, M.B.—a daughter.
- MILNER.—On March 10th, 1934, at Blythwood, West Common, Harpenden, to Monica, wife of J. G. Milner, F.R.C.S.—a son.
- RECORDON.—On March 5th, 1934, at 51, Bateman Street, Cambridge, to Frieda (*née* Robertson), wife of Dr. Esmond Recordon—a son.
- SPENCE.—On March 23rd, 1934, at 20, Devonshire Place, W. 1, to Lena (*née* Hutchison), wife of Dr. A. W. Spence—a son.

MARRIAGE.

MORGAN—KEMP.—On January 11th, 1934, at St. Margaret's, Warnham, near Horsham, by the Rev. Canon Bartlett, assisted by the Rev. F. S. Farebrother, Dr. George Sydney Morgan, of Newlands, Horsham, second son of the late Mr. G. H. Morgan and of Mrs. Morgan, of Shrewsbury, to Dorothy Joan, second daughter of Dr. and Mrs. J. H. Kemp, of Woodchester, Horsham.

DEATHS.

- HOPE.—On March 24th, 1934, at King Edward VII Hospital, Windsor, following an operation, Dr. John Lamplugh Allen Hope, M.R.C.S., L.R.C.P., of Devonshire House, Addlestone, Surrey, eldest son of the late Rev. Sackett Hope, of Oxford and Folkestone, aged 67.
- SYLVESTER.—On March 23rd, 1934, at Bournemouth, Lt.-Col. George Holden Sylvester, late R.A.M.C.

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: National 4444.

St. Bartholomew's Hospital



JOURNAL.

"Æquum memento rebus in arduis
Servare mentem."

—Horace. Book ii, Ode iii.

VOL. XLI.—No. 8.]

MAY 1ST, 1934.

PRICE NINEPENCE.

CALENDAR.

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| Tues., May | 1.—Dr. Graham and Mr. Roberts on duty. |
| Wed., " | 2.—Surgery: Clinical Lecture by Sir Charles Gordon-Watson.
Cricket Match v. Wanderers. Home. |
| Fri., " | 4.—Medicine: Clinical Lecture by Lord Horder. |
| Mon., " | 7.—Prof. Fraser and Prof. Gask on duty.
Special Subject: Clinical Lecture by Mr. Bedford Russell. |
| Tues., " | 8.—Lord Horder and Sir Charles Gordon-Watson on duty. |
| Wed., " | 9.—View Day. |
| Fri., " | 11.—Medicine: Clinical Lecture by Dr. Hinds-Howell, Dr. Hinds-Howell and Mr. Harold Wilson on duty. |
| Sat., " | 12.—Cricket Match v. U.C. Old Boys. Home. |
| Mon., " | 14.—Special Subject: Clinical Lecture by Mr. Elmslie. |
| Tues., " | 15.—Dr. Gow and Mr. Girling Ball on duty. |
| Wed., " | 16.—Surgery: Clinical Lecture by Mr. Harold Wilson. |
| Fri., " | 18.—Medicine: Clinical Lecture by Dr. Graham. |
| Sat., " | 19.—Cricket Match v. Metropolitan Police. Away. |
| Last day for receiving matter for the June issue of the Journal. | |
| Sun., " | 20.—Whit Sunday. |
| Mon., " | 21.—Bank Holiday. |
| Tues., " | 22.—Prof. Fraser and Prof. Gask on duty. |
| Wed., " | 23.—Surgery: Clinical Lecture by Mr. Girling Ball.
Cricket Match v. The Times C.C. |
| Fri., " | 25.—Medicine: Clinical Lecture by Dr. Gow.
Lord Horder and Sir Charles Gordon-Watson on duty. |
| Sat., " | 26.—Cricket Match v. St. John's College, Cambridge. |
| Mon., " | 28.—Special Subject: Clinical Lecture by Mr. Bedford Russell. |
| Tues., " | 29.—Dr. Hinds-Howell and Mr. Harold Wilson on duty. |
| Wed., " | 30.—Surgery: Clinical Lecture by Mr. Girling Ball. |
| Thurs., " | 31.—Cricket Match v. M.C.C. Home. |

EDITORIAL.



THE advent of May brings to Hospital, as to our own homes, that season of annual cleaning which overthrows the equilibrium of everyday life and disturbs the tranquillity for which the average human mind for ever craves.

Painters, window cleaners, wall scrubbers go about their tasks with grim determination, not caring that in the Square our favourite seat is coated by fresh paint, or that for the moment the daily activities are entirely chaotic. It is for "View Day" that this fevered toil is undertaken, and the Hospital, like a little girl in her new Sunday frock, is made to be on its best behaviour for a few brief hours.

What an air of artificiality the *Alma Mater* wears on this historic afternoon—who associates the Square with Ascot as a fashion parade or Elizabeth Ward with the crowds of admirers that might be in attendance at a Wembley Cup Final! To us the nooks and crannies bring back memories of the real Bart.'s we know so well—of the mother's pain and joy as we delivered her first child at early dawn, of the Square's winter shadows as we passed across to do our evening ward round, of lordly processions in the wards with some chief on hot summers' afternoons, and of pungent ether vapour. This is the place we love and live in, but on View Day, like pilgrims, we visit old battle-fields where so many of our past victories and defeats were made.

This spring cleaning, which affects our external comfort so considerably, should permeate internally to be a thorough success. Even the best brains need occasional dustings, so let us depart annually from the rut of our supposed Orthodoxy and explore the realms of other people's Heterodoxy. A mental view-day when we could display our current ideas and discuss them with

people from other schools should be instituted by someone with sufficient courage.

* * *

Once more, with the passage of time, an Editor has sung his swan-song and has passed from the narrow limits of the life here around the Fountain and the plane-trees to the expanses of the great world outside.

It is our sad lot to record the retirement of Mr. J. M. Jackson and to attempt to give expression to our feelings of genuine regret. Just as sincere are our wishes for his good success and the hope that he will receive the distinction in his career that so many of his predecessors have obtained.

* * *

We congratulate Dr. E. R. Cullinan on his election to the Fellowship of the Royal College of Physicians.

* * *

We have received the following notice from the Secretary of the Women's Guild:

"We should like to issue a cordial invitation to everyone interested in the Hospital and its work to be present at our Annual View Day Meeting, to be held in the Great Hall on Wednesday, May 9th, at 4.15 p.m.

"This year we have been very fortunate in securing the patronage of the Lady Mayoress. Bishop Paget, formerly Bishop of Chester, whose name in connection with the Hospital is too well known to need further introduction, and Major Ian Hay Beith, C.B.E., M.C., who also will be remembered not only by his books, but by the delightful speech which he made at our Annual Meeting a few years ago, have kindly consented to be our Speakers.

"Please come and bring as many friends as possible, so that we may have a large audience to show our appreciation.

"Tea will be served at the end of the meeting, to which all are cordially invited."

Memories of past meetings will be sufficient, we feel, to direct the footsteps of all to a packed Great Hall when the attraction of the wards and the fascination of "Lizzie" begin to pall.

* * *

Our congratulations are offered to Mr. H. J. Seddon on sharing with another surgeon the distinction of winning the Robert Jones Medal of the British Orthopaedic Association, and to Mr. H. Jackson Burrows for being awarded a certificate of honourable mention in the Jacksonian Prize at the Royal College of Surgeons.

A very enjoyable afternoon and evening were passed on Saturday, April 14th, when the Rugby Football Club held their Inter-Firm Seven-a-side Tournament and a dance, in aid of the College Appeal Fund.

The magnificent cup presented by the Staff was won by the Yellow Firm, resplendent in their flavined jerseys, who defeated the Pinks in the final. Mr. Girling Ball awarded the Cup and expressed the hope, echoed by all, that the function would become an annual one.

* * *

We have received a letter announcing a tour in the U.S.S.R. for students of the London hospitals during the next summer vacation. The object is the study of contemporary developments in medicine and public health, and is attained by visits, conducted by the authorities, to hospitals, prophylactoria and crèches.

The trip will be by the Intourist Service to Leningrad and Moscow, and will occupy three weeks. The cost will be approximately £1 per day inclusive. We will be glad to give further particulars to any interested.

* * *

COLLEGE APPEAL FUND.

	£	s.	d.		†
Staff	12,529	4	10	(71)	
Demonstrators	1,674	11	0	(67)	
Students	712	0	5	(284)	
Old Bart's men:					
Bedfordshire	12	11	6	(4)	(26)
Berkshire	96	1	0	(14)	(37)
Buckinghamshire	74	19	0	(13)	(29)
Cambridgeshire	165	14	0	(13)	(42)
Cheshire	1	1	0	(1)	(26)
Cornwall	22	2	0	(5)	(39)
Cumberland	5	0	0	(1)	(6)
Devonshire	19	14	0	(4)	(17)
Devonshire	557	14	0	(52)	(117)
Dorset	52	1	0	(14)	(30)
Durham	16	6	0	(3)	(11)
Essex	229	19	6	(17)	(69)
Gloucestershire	212	13	6	(20)	(66)
Hampshire	406	14	0	(38)	(134)
Herefordshire	13	3	0	(4)	(11)
Hertfordshire	26	3	0	(13)	(23)
Huntingdonshire					(1)
Isle of Wight	181	13	0	(12)	(25)
Kent	58	3	0	(61)	(146)
Lancashire	91	4	6	(12)	(82)
Leicestershire	133	12	0	(6)	(28)
Lincolnshire	47	6	0	(13)	(25)
Middlesex	382	3	0	(18)	(68)
Norfolk	150	7	6	(18)	(60)
Northamptonshire	54	4	0	(4)	(17)
Northumberland	101	1	0	(2)	(11)
Nottinghamshire	13	13	0	(2)	(28)
Oxfordshire	185	3	0	(18)	(29)
Rutland					(2)
Shropshire	35	9	0	(8)	(22)
Somersetshire	1013	10	0	(26)	(43)
Staffordshire	194	18	0	(6)	(37)
Suffolk	263	11	0	(17)	(49)
Carried forward	£20,292	10	9		

	£	s.	d.		†
Brought forward	20,292	10	9		
Surrey	434	16	6	(47)	(180)
Sussex	272	2	0	(18)	(170)
Warwickshire	178	1	6	(18)	(56)
Westmorland	1	0	0	(1)	(5)
Wiltshire	97	11	0	(11)	(26)
Worcestershire	153	19	6	(24)	(24)
Yorkshire	270	4	6	(21)	(101)
Wales	56	4	0	(12)	(150)
London	2,747	16	8	(176)	(971)
Channel Islands	10	0	0	(1)	(9)
Scotland	14	4	0	(4)	
Abroad	48	5	0	(7)	
South Africa	326	10	6	(17)	
Canada	113	2	0	(8)	
East Africa	72	7	0	(8)	
West Africa	146	10	0	(5)	
India	152	0	0	(7)	
Ceylon	4	0	0	(1)	
Syria	2	2	0	(1)	
U.S.A.	3	0	0	(1)	
Ireland	14	14	0	(3)	
North Africa	1	0	0	(1)	
North Borneo	5	5	0	(1)	
Australia	12	2	0	(3)	
Egypt	4	2	0	(2)	
Malay States	6	0	0	(2)	
China	45	7	4	(7)	
Siam	10	0	0	(1)	
France	50	0	0	(1)	
Trinidad	22	2	0	(2)	
British West Indies	23	1	0	(3)	
New Zealand	2	1	0	(2)	
Services	524	14	0	(34)	
Others	31,810	9	1	(286)	
	£57,929	4	10		

† Number of Bart's men in County.

OBITUARY.

DR. C. E. TANNER.

TANNER, C. E. TANNER, who died last April, was born in 1861, the third of the five sons of a Wiltshire yeoman. He was educated at Clifton College, at St. Bartholomew's Hospital, and at the Newcastle-upon-Tyne Medical School, where he graduated M.D. of the University of Durham in 1888. He acted for a year as House Physician at the Royal Free Hospital, and settled in practice at Farnham, in Surrey. Here his handsome presence, his courteous manners and his sound professional knowledge soon gained him the large practice which he carried on by means of a high dogcart drawn by a blood mare. Paying a tribute to him on one occasion, Archbishop (Lord) Davidson said that the doctor had known successively six bishops, occupants of Farnham Castle, and that five of them had been his patients. He had known them inside and out. He had mended them in heads and hearts, and legs and middles, and in those ways there

had sprung up an intimacy of home life, a relationship of affection such as they entertained for those in home life. Such a relationship Dr. Tanner also maintained with the richest and the poorest of his patients, with soldiers and lawyers, with country gentlemen and with labourers. Could greater praise be given to any medical man?

Throughout his life he took an active part in the affairs of Farnham. He was medical officer for the Rural District Council, and to the Infirmary. He was the virtual founder of the Children's Convalescent Home at Tilford, for a patient gave him a sum of money to be applied at his discretion. He was a moving spirit in establishing the Farnham swimming-baths, and he was instrumental in forming the Wey Valley Water Company. He was, too, a Justice of the Peace for the County of Surrey. He retired from practice in 1924, and was the recipient of a testimonial from his many friends "in token of their gratitude and affection". He married in 1905 Mary Louise Graham, who was then superintendent nurse at the Farnham Infirmary. She survives him with a son and three daughters. Husband and wife, with the help of some enthusiastic guardians, soon brought the Infirmary to a high pitch of excellence.

D'A. P.

CASES FROM THE WARDS.*

II.

"Complete investigation of the genito-urinary tract is demanded in all cases of urinary infection."



UNLESS complete investigations of the urinary tract are made in all cases of infection associated therewith, many patients will be doomed to persistent or recurrent illnesses which can be cured. It is such a common experience that palliative methods of treatment have been tried before investigations have been suggested that it seems desirable to consider the two following cases. Many lessons can be drawn from them.

CASE 1.—A female, *et. 26*, came under the care of Dr. Geoffrey Evans recently, with the story that two and a half years ago, following an attack of influenza, she had pains all over the abdomen and in both lumbar regions. The attack lasted for a week and was accompanied by fever. At the same time she noticed that there was an increased frequency of micturition, *F. = 6-7/1-2*. She also had a slight pain on passing her water. The acute symptoms rapidly subsided, but the increased frequency persisted.

Six months ago an infection of her urine was discovered, and she was given a ketogenic diet, which had no effect in improving her condition. Little further notice was taken of this infection until she was admitted to the Hospital; she was regarded as a neurotic patient.

* Notes of a Clinical Lecture given at St. Bartholomew's Hospital on Wednesday, February 21st, 1934.

On examination she appeared to be a perfectly healthy girl, and no abnormality could be discovered in her abdomen; neither kidney could be felt. The urine was not obviously very turbid, but a few pus-cells were found on standing; on culture a pure growth of the *Bacillus coli communis* was obtained.

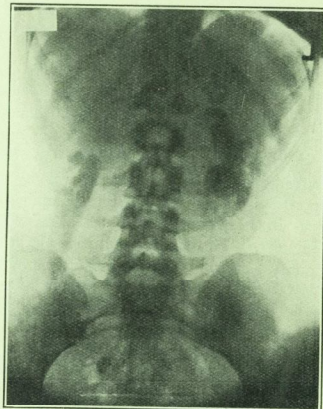


FIG. 1.

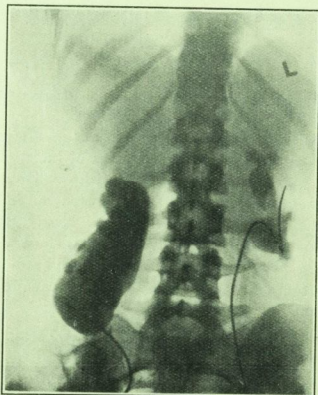


FIG. 2.

As diuretic treatment and general attention to the bowel, etc., had no effect, further investigations were carried out.

Radiography.—(1) A straight X-ray of the urinary tract showed no abnormality.

(2) An intravenous pyelography (Fig. 1) by the injection of uroselectan was said to show that both pelvis were dilated, and the right kidney was rather low.

The blood-urea was 35 mgm.%.
 Urea-concentration test.—1st hour, 65 c.c. of urine, 1.75% of urea; 2nd hour, 45 c.c. of urine, 2.65% of urea; 3rd hour, 58 c.c. of urine, 2.55% of urea.

Cystoscopy.—The bladder was normal, except that there was some slight congestion of the trigone. Both ureteric orifices had normal appearances, and the efflux seen from each side was apparently clear.

Ureteric catheterization.—From the right kidney the urine contained pus-cells, red blood-cells, and a pure culture of the *Bacillus coli communis* was obtained.

From the left kidney there were no abnormal constituents in the urine, and the cultures were sterile.

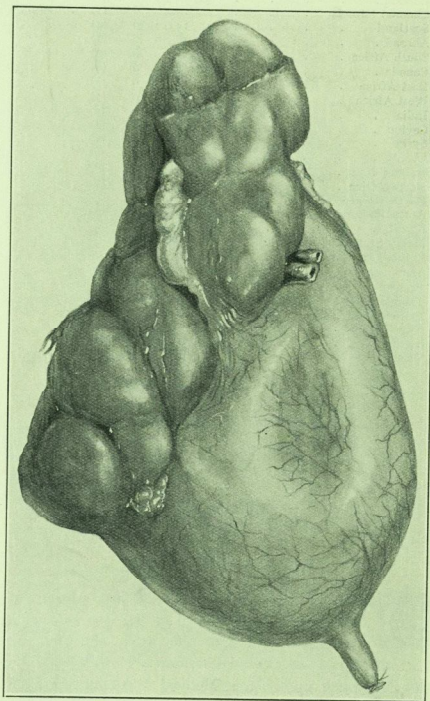


FIG. 3.

A retrograde pyelography (Fig. 2) showed much the appearances shown by the intravenous pyelogram on the left side; the pelvis held only 12 c.c. of sodium bromide, which was almost within the range of normality, although perhaps a little in excess. The right pelvis, however, held 50 c.c. of sodium bromide and was then not completely distended, and gave the typical appearances of a pelvic hydronephrosis.

The right kidney was removed, and is seen (Fig. 3) merely to consist of a bag with a small amount of renal tissue forming a cap over the distended sac. The distension commences at the uretero-pelvic junction.

Four weeks after the operation the patient was free from symptoms, and the urine was clear and uninfected.

CASE 2.—A female, at. 2, admitted under the care of Dr. Harris for "trouble with her water".

At the age of three months it was noticed that the urine was thick; otherwise the health of the baby was good.

When she was nine months old her urine was discovered to be infected, and medicinal treatment was tried, without effect.

Six months before admission the child had some fever, and there had been many similar attacks of fever since that date. The attacks lasted for two or three days, and came on every three or four weeks, but had been increasing in frequency during the past three months. The urine became very offensive in the attacks.

The child did not look well, and was losing weight. On examination of the abdomen neither kidney could be felt.

The urine was very turbid and contained much pus; a pure culture of the *Bacillus coli communis* was obtained.

The child was given medicinal treatment without any effect, and it was then decided to investigate further.

Radiography.—(1) Plain films showed no abnormality in the urinary tract.

(2) The dye, after an intravenous injection of uroselectan, failed to concentrate in either kidney.



FIG. 4.

Cystoscopy.—The left ureteric orifice appeared to be normal, and the efflux clear. The right ureteric orifice was swollen, and so oedematous that the orifice could not be seen; neither was there any obvious efflux from it.

Retrograde pyelography showed a normal left renal pelvis which held 2½ c.c. of sodium bromide.

Three weeks later a further cystoscopic examination was made, and both ureteric orifices were easily seen and appeared to be normal.

Ureteric catheterization of the left kidney again showed no abnormality in the urine, which was sterile on cultivation, whereas the urine from the right ureter contained pus-cells and a pure growth of the *Bacillus coli communis*.

A right-sided retrograde pyelogram and ureterogram (Fig. 4) was then made, and it was found that the renal pelvis held 15 c.c. of sodium bromide, and gave the characteristic appearance of a pelvic hydronephrosis and a greatly dilated ureter down to the uretero-vesical junction.

The right kidney and ureter were completely removed. The kidney merely formed a shell over a sac, and the ureter was enormously dilated, and showed complete dilatation down to the uretero-vesical junction. Although the kidney looked fairly normal from the surface, the cavity completely distended it (Fig. 5).

Five weeks later the child appeared to be quite well, the wound healed, the urine clear, containing no pus-cells, and sterile on cultivation.

The following lessons may be learnt from these two cases:

1. It is an obvious practice that in cases with relatively obscure symptoms all the tracts of the body must be carefully examined. The frequency with which a complete investigation of the urine is omitted, however, is curious, with the result that relatively minor degrees of infection are completely overlooked. The first case exemplifies this fact, for the patient has been labelled as a neurasthenic, and the relatively trivial abdominal

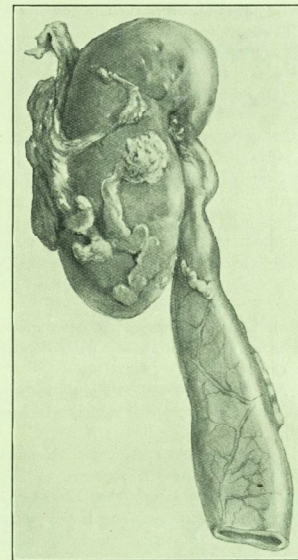


FIG. 5.

symptoms had been passed over; as a result of the incorrect diagnosis she had lost her job, whereas there really was a definite and major cause for her troubles.

2. It is unwise to try the effect of medicinal or any other form of treatment in cases of chronic urinary infection without carrying out the necessary investigations which may discover a predisposing factor.

This statement may sound a little too wide, but let it remain so if only it will stimulate the carrying out of these procedures.

In my experience, there is a tendency amongst practitioners to be satisfied with the diagnosis of "infection of the urinary tract", and to treat the patient

by some method, dietetic or medicinal, often fashionable at the moment, without making a proper effort to discover the origin of the infection or the presence of some defect of the urinary tract which keeps it up.

These remarks do not apply to acute infections of the urinary tract. They should, quite correctly, be treated by medicinal and dietetic methods, and many of them will completely clear up. Often, however, this fails; in these cases, and the chronic or recurrent cases, it is surprising how often some predisposing factor can be found if the seeking for it is sufficiently energetically pursued. By such a discovery many miserable lives can be made happy.

3. There are difficulties in the way, for the investigations called for are often laborious and extensive; moreover, the results obtained may be difficult to interpret.

The investigations required may be taken in the following order:

(a) *Examination of urine.*—It is quite clear that the nature of the micro-organism and its association with pus-formation is an essential finding of a full examination of the urine before the diagnosis of an infection can be made. It is not sufficient to guess that this is present by observing a "turbid urine with a fishy smell".

An accurate analysis of catheter specimens of urine is required. Normally passed urine is too often contaminated.

(b) *Radiography.*—A straight radiogram is essential to demonstrate or exclude the presence of calculi.

(c) *Cystoscopy.*—A cystoscopic examination is required to indicate the presence or absence of cystitis. Indications may thus be obtained as to whether it is associated with (i) intra-vesical lesions; (ii) prostatic or urethral lesions; or (iii) perivesical lesions.

If associated with upper urinary tract infections, the appearances of the urethral orifices may indicate the presence of a unilateral focus, which may be further confirmed, in gross infections, by the character of the efflux from the ureter.

(d) *Ureteric catheterization.*—Gross infections and the lesser degrees of turbid urine not seen by cystoscopy will be confirmed by ureteric catheterization.

(e) *Pyelographic examinations* are called for to demonstrate the presence or absence of predisposing lesions of the kidneys.

4. The ureteric catheterization in both cases was the means of discovering that a unilateral infection of the urinary tract was present.

5. It is not sufficiently appreciated that unilateral infections are fairly common, and that these are dependent on some inherent defect in the urinary passages. It is true that bilateral infections without any obvious predisposing cause are met with; others are associated with obvious causes, such as enlargement of the prostate, strictures of the urethra, renal calculi, etc. It is quite clear, however, that without these investigations the unilateral cases cannot be segregated, and many patients lead the lives of invalids for want of sufficient care in this direction.

6. Pyelography was the essential examination which led to the discovery of the deformities of the upper urinary passages.

The interpretation of the pictures obtained calls for some comment. Take the intravenous pyelograms. In the first case it was suggested that both kidneys were at fault; in fact, it was believed that the left kidney was really more likely to be the seat of the trouble than the right, and that the indefinite shadow shown in the right kidney was due to some defect in the concentration of the dye, which might be disregarded.

In the second case the dye did not concentrate in either kidney up to the full period allowed, and thus led to the suspicion that both kidneys were working inefficiently.

These interpretations, however, did not fit in with the findings of the ureteric catheterization, and therefore retrograde pyelography was resorted to.

In the first case the retrograde pyelogram of the left kidney showed that the pelvis, which appeared to be considerably dilated, was normal, or a little larger than normal; there is a possible explanation of this, namely, that because the right kidney was completely destroyed, there was some compensatory hypertrophy of the left. Secondly, a considerable hydronephrosis of the right kidney of the pelvic type was found, which was not at all clearly shown in the intravenous pyelogram.

The retrograde pyelograms in the child were of considerable importance, in that retrograde pyelography in a child of this age is not easily carried out. It was made possible by a technical detail recently discovered by my Chief Assistant, Mr. Underwood, which enabled us to get satisfactory pictures of both kidneys, showing gross dilatation of the right kidney and the ureter, with a normal left urinary tract.

The different outlook suggested by these observations, which more closely fitted in with that of the previous examinations, must necessarily teach us that uroselectan pyelography does not always give accurate information, and that the greatest care is required in the interpretation of the pictures obtained by this method. The method may serve as a valuable indicator

in suggesting which kidney is at fault, when neither gives sufficient evidence of its troubles by symptoms or ordinary physical signs, or which side of the urinary tract requires further investigation; but it must not at present be regarded as a procedure which replaces the retrograde method. Many pitfalls await those who rely on it. It is not an uncommon experience, for example, that normal kidneys fail to concentrate the dye; it must be recognized that the absence of shadows does not always mean that the kidney is not functioning properly. Thus, it follows that in every case of doubt it is essential for the appearances seen to be confirmed by ureteric catheterization and retrograde pyelography. Take another point: It is important to have some knowledge of the capacity of the renal pelvis, as this is the only way of discovering whether a minor degree of hydronephrosis is present. This can only be estimated by the retrograde method. The appearance of the intravenous radiogram may, as in the first case, suggest the presence of a dilated pelvis, quite wrongly. Unless the amount of fluid held by the pelvis is estimated, the diagnosis may be faulty.

From the patient's point of view intravenous pyelography has one advantage, namely, that a cystoscopic examination is avoided; this is a procedure which is feared by so many, and requires a specialist to carry it out. This warning, with regard to intravenous pyelography, therefore, is necessary if the method, at the moment fashionable and valuable in some cases, is not to fall into disrepute.

7. These two cases are allied in that they both show the pelvic type of hydronephrosis; in the child it was associated with a hydro-ureter. They are commoner lesions than is generally realized; their origin is obscure, but there is some reason for believing that they have a congenital origin. There is no need to discuss their pathology here.

The point which requires to be emphasized is that these minor degrees of hydronephrosis, not sufficiently large to give rise to physical signs on abdominal examination, cannot be discovered except by pyelography.

8. In both cases the kidneys were removed, and the findings are described in the records. The question of treatment will not be further considered. In passing, however, it is just worth mentioning that it is for this type of case that lumbar sympathectomy and gangliectomy is advocated by some. It is hard to conceive that sympathectomy could do any permanent good in such cases, for apart from the infection, there is generally an absence or great diminution of renal tissue.

9. It is worth indicating that an investigation of the urinary tract is not all that may be required in these cases of infection. The predisposing factor may be

outside the urinary tract. Here is the record of one further instructive case to illustrate this point:

A woman was admitted to the hospital some years ago with an infection of her urinary tract and severe painless hamaturia. The infection was regarded as the cause of the bleeding, and medicinal treatment was first advocated. The hamaturia, however, became so severe that her red blood-cells fell to 2,300,000 per c.mm. and the haemoglobin to 30%. It was shown that the blood was coming from her right ureteric orifice and that the infected urine was coming from the right kidney, whereas the urine from the left side was sterile.

A retrograde pyelogram was made, which showed a very mild dilatation of the renal pelvis.

The hamaturia was so severe that it was decided to remove the kidney, which otherwise might have been dealt with by some palliative procedure, such as nephropexy. On section the kidney was found to be quite normal, and the source of the hamaturia did not appear to be in the kidney, which was proven by the fact that on the next morning the urine still contained blood and the infection remained.

The bleeding slowly subsided, and the patient went to a convalescent home, where she developed an attack of acute appendicitis, symptoms of which she had never previously had. At the same time she had a marked infection of her urine.

She was brought back to the hospital and her appendix was removed. It was gangrenous, and was adherent to the stump of the ureter, which had been left behind. Within three days of the removal of the appendix the urine was sterile and has remained so ever since.


There is no doubt that the infection in this case was caused by the adhesion of an inflamed appendix to the urinary tract.

10. Enough has been said to show that with sufficient care, and that with these possibilities in mind, the origin of a urinary infection is always worth looking for.

Our motto should be that instead of trying palliative treatment first, give complete investigation and thereby accurate diagnosis a chance.

W. GIRLING BALL.

THE ADMINISTRATION OF ANALGESIA IN LABOUR BY MEANS OF DR. MINNITT'S GAS AND AIR APPARATUS.

 T the Wellhouse Hospital, Barnet, during the past winter months I have had the very great privilege of supervising the administration of nitrous oxide and air to 100 maternity cases, all of whom made use of the Minnitt gas and air machine for self-administration of analgesia in labour.

Dr. Minnitt, the inventor, and Mr. Charles King, the manufacturer, very kindly placed two machines at our disposal, so that we were able to form a very good opinion as to the advantages and possibilities of this means of self-administration of analgesia in maternity work.

The Medical Superintendent of the Wellhouse Hospital insisted that any method for giving analgesia in maternity work at this hospital must fulfil certain conditions:

(1) The patient must be given satisfactory relief from pain.

(2) The method in use must be helpful to the midwife or nurse, and must not hinder her in her work in any way. (For example, excitement of the patient and cyanosis of the baby had to be absolutely avoided.)

(3) The apparatus in use must be simple to use and quite "fool-proof".

(4) Absolute safety was required.

(5) Normal labour must be in no way interfered with.

(6) The method had to be one which could be used without constant medical supervision.

(7) Undue expense had to be avoided.

Any process which did not in every respect come up to this standard of excellence was of no value, and would be discontinued immediately.

The various methods for maternity analgesia which had been in use at other hospitals and institutions did not appear altogether satisfactory, and it was evident that there was ample scope for new apparatus and new technique.

It did, however, appear that the method advocated by Dr. Minnitt might be a very great advance on anything we had seen up to the time of our investigation.

I was therefore invited to supervise in a voluntary and research capacity, under the direction of the Medical Superintendent, a series of maternity cases to be given gas and air analgesia by means of Dr. Minnitt's machine.

Only those patients who were in labour between 8 a.m. and 10 p.m. were to receive the gas and air.

The results of our investigation have not only proved most satisfactory, but have exceeded our expectations in many ways, and, as this method which we have used is not generally known, I think that it may be of interest to Bartholomew's men to hear something of our experiences.

A report on the results of our first 64 cases was read at the Liverpool Medical Institute by Dr. Minnitt on February 22nd, 1934, together with his own report on a longer series of cases attended at the Liverpool Maternity Hospital.

I think that the results of the investigation do show that the method of Dr. Minnitt is one eminently suitable for the maternity work of general practice. There is no difficult technique, and we have the enormous advantage that there is no necessity for the presence of a highly skilled anaesthetist experienced in maternity work.

This is of the greatest importance both in hospital and private practice.

Dr. Minnitt's machine is similar to the nitrous oxide

half of McKesson's machine, with a device for allowing a definite proportion of air to be mixed with the gas.

For this purpose there are five air-holes on the top of the machine. With all these five air-holes open, the machine delivers about 35% nitrous oxide in air.

The weight of the machine is 7½ lb. without cylinders, and the amount of gas consumed is, on a fair average, 35 gallons per hour (intermittent flow).

In all, 100 women were given gas and air in their confinements between November 4th, 1933, and March 22nd, 1934, at the Wellhouse Hospital.

There were 58 primiparæ and 42 multiparæ in this series, and of these, 16 primiparæ and 24 multiparæ found *great relief*; 42 primiparæ and 16 multiparæ felt *no pain whatsoever*; 2 found *some relief* after the gas and air was started. By *great relief* I mean that there was complete absence of evidence of distress during labour, and that the patients themselves subsequently stated that the method had given them great relief from pain.

52 primiparæ and 41 multiparæ made use of the apparatus up to and including delivery; 6 primiparæ and 1 multiparæ until delivered under general anaesthesia (6 forceps cases and 1 breech).

There were 3 breech cases delivered under gas and air.

There were 2 stillbirths, but these were not due to the gas and air. One was a difficult forceps delivery, and one gave no foetal heart-sounds long before delivery. This latter was sent to hospital as a specially difficult case.

Length of time during which gas was given varied from 10 minutes to 14 hours.

The most important advantage of this method is that the analgesia is self-administered, and that the patient does not lose consciousness and can co-operate with the accoucheur, the machine being automatic in action. This advantage has been particularly stressed by the patients themselves. They find great satisfaction in that they are relieved of their pain, yet remain conscious of their surroundings and are aware of the presence of the sister in charge.

No premedication was given to patients immediately prior to the administration of the gas, although a few had had morphia some hours earlier.

Every patient in her own handwriting recorded her opinion of the method, and no attempt was made to influence her in any way.

There was no selection of cases; these were taken as they came.

The administration of gas and air was usually started at about full dilatation of the cervix. Owing to my being a non-resident anaesthetist there were a few very

short administrations, as I could not always get to the hospital as promptly as I could have wished.

For the first 50 cases I was actually present for the entire time during which gas and air was administered, but as the series progressed, the supervision was left more to the nursing staff, until it was thought that they might, with safety, take entire charge.

Towards the end of the series the nursing staff showed that they were perfectly capable of dealing with a case entirely "on their own", their results being quite as satisfactory as those I had obtained.

They were, of course, in an advantageous position in that they could, at a moment's notice, summon medical assistance if required, but they showed great enthusiasm in their work and assisted me to their utmost.

In no case did they require medical assistance for any reason connected with the administration of gas and air.

Now there are certain difficulties and objections which seem to have been inseparable from the use of nitrous oxide analgesia in labour up to the present.

These may be briefly enumerated:

(1) The cost and weight of apparatus required.

(2) The presence of a skilled anaesthetist at the bedside of the patient for a prolonged period.

(3) Except in highly skilled hands, possible cyanosis of the baby.

(4) Excitement of the mother.

(5) Vomiting.

We must therefore consider whether these apply to the use of Dr. Minnitt's machine.

(1) The cost and weight of apparatus: The machine without cylinders weighs 7½ lb., and the cost, so far as one is able to judge at present, will not be prohibitive.

(2) The method is truly described as self-administrative. The patient is given the face-piece and told to apply it to her face and breathe in and out when a pain comes. Any fairly intelligent woman will do this, and there is no necessity for the presence of a skilled anaesthetist.

In the writer's opinion the supervision of the administration can well be left to a nurse after very brief instruction.

(3) When the patient is breathing regularly in and out through the face-piece, cyanosis does not occur.

When, however, she holds her breath and pushes down in the second stage of labour, cyanosis did occur in a few cases in our series.

This was not of a serious or dangerous degree, and was overcome by telling the patient to stop pushing and take a deep breath, which she invariably did.

The cyanosis which was observed had no ill-effect

whatever on the babies, as all these cried lustily on being born. There were no blue babies.

(4) Excitement was notably absent, and it was remarked that, in many cases where the patient had been very troublesome before the analgesia was started, all excitement disappeared.

The nurses were of the opinion that the patients having gas and air were much more easy to control than those having no analgesia.

To my mind the most important advantage of this method is that it not only helps the patient, but helps the nurse also.

(5) In our series vomiting only occurred in two cases, one of which had had a general anaesthetic a few hours previous to the gas and air.

None of the other patients complained of nausea or vomiting, and most took fluids during the administration, between the pains.

We must therefore come to the conclusion that Dr. Minnitt's machine gives us a method for the relief of pain in maternity work, which has most of the now well-known advantages of nitrous-oxide-oxygen technique without its disadvantages.

At the present time gas and air has not been found to give sufficient depth of anaesthesia for the application of forceps or for extensive repairs to the perinaeum, although it does suffice for the insertion of one or two stitches into the perinaeum.

We are as yet at the beginning of a road—perhaps it may be a long road—which will lead to analgesia in labour for all women.

But we must all be most grateful to Dr. Minnitt for having shown us what great advantages and possibilities lie in the use of nitrous oxide and air analgesia in labour.

Finally, I would pay tribute to the Medical Superintendent and the nursing staff of the Wellhouse Hospital for all their encouragement and support.

Throughout the investigation I was in constant touch with Dr. Minnitt, who gave us much assistance and advice.

JOHN ELAM.

RHYME.


Mary has a little cup

And very rightly crows;

I much regret to tell in verse

What should be told in pros.

PINK DISEASE.

RST described in 1903 by Selter in Germany, this rather uncommon disease of infancy has now earned its place as a recognizable disorder of world-wide occurrence. That it still remains in some degree of obscurity is to be attributed partly to the fact that recovery is usual, and so the morbid anatomy of the disease has been studied by only a few observers, and partly to the peculiar difficulties associated with the diagnosis and investigation of disease in infants. Since its original description, no fewer than seventeen names and methods of description have been bestowed upon it by various authors, but the titles of "pink disease" and "erythroedema polyneuritis" are the usually accepted ones in English medicine. Because it is believed that the disease is less uncommon than is usually thought to be the case, this brief paper deals with the disease as a whole, especially as exemplified by two recent cases studied in the Children's ward of this hospital.

CLINICAL FEATURES.

Pink disease is so called because a frequent and peculiarly striking manifestation of it is a pink colour of the hands and feet, but it is to be realized at the outset that this is but one feature of a disease characterized by a varied symptomatology with several clinical types.

The age-incidence is strictly limited to the period of infancy, most cases occurring between the ages of 9 and 18 months. This striking age limitation brings pink disease into the same age-group as infantile rickets—a fact which may eventually prove to have a bearing upon the aetiology of the disorder. There is no special incidence in either sex.

The disease commences insidiously, there being often a history of a febrile illness—a cold or an attack of "influenza", following which is a quiescent period of a few weeks, and then a gradual unfolding of the clinical picture. Case 1 will illustrate the usual clinical type:

CASE 1.—J. H.—, a female breast-fed infant, developed normally until the age of eight months, when she was noticed to be becoming irritable. There was constant crying, and she lay in her cot without making any effort to support herself. Gradually feeding became difficult, the breast being refused, and in consequence weight was lost. Muscular weakness increased, so that she lay listlessly, though there were continual movements of the hands and feet. At the age of nine months the latter were observed to be mildly pink, and the skin appeared to be peeling off. A nasal discharge had been noticed shortly after the onset of the disease and had persisted. When seen at the age of 9½ months the child presented a characteristic picture, lying curled up in her cot with an expression of extreme misery on her face. She would cry and scream frequently, especially when fed or washed. At this time she weighed only 14 lb. 3 oz., and was still losing weight on admission, great difficulty being experienced in getting her to take her feeds. There was slight

irregular fever of the order of 99.5°–100° and tachycardia up to 160, but the striking clinical features were the irritability, the anorexia, muscular weakness, and the condition of the hands and feet. The muscles of the limbs were extremely flabby and the tone poor, but the tendon reflexes were all obtained. The hands and feet exactly resembled the classical description of "looking as though they had been dipped in boiling water". The hands were particularly affected, and appeared puffy and red, while the skin was peeling off in large flakes. They always felt cold to the touch. Response to pin-prick was diminished over a wide area of the arms and legs, the hands appearing anaesthetic. Elsewhere the skin was normal on admission, though rather clammy, but at intervals while under observation a fine papular "sweat rash" appeared on the trunk and limbs. Finally, a degree of stomatitis was present, the frenulum linguae being ulcerated.

The above state persisted for the first fortnight and then diarrhoea set in, while fever increased in degree. By adjusting the feed from sweet cow's milk to lactic acid milk this was checked, and clinical improvement then set in, the weight steadily increased, and on discharge, at the age of 12 months, she was apparently well, though the hands were still pink and she was still rather irritable.

This patient presented a picture so characteristic that the diagnosis of pink disease could be made on sight, yet there were several clinical features often seen in pink disease which she did not exhibit. Thus, insomnia, resistant to hypnotics, is often present, while there may be photophobia. Then the tendon reflexes are frequently greatly diminished or absent. The stomatitis was of a mild degree in this case, but is often severe, the teeth becoming loosened and falling out. Often the child has not only pink hands and feet, but a pink nose, and the latter seems to irritate so that the subject burrows with its nose in the pillow. The hair may be affected and may fall out. Case 2 illustrates the occurrence of the same disorder of general health with a relative absence of change in the hands and feet.

CASE 2.—G. F.—, a female infant, developed normally and was breast-fed until the age of 9 months, when she had "influenza", and following this great difficulty with her feeding was experienced. Bottle-feeding was attempted, but milk was spat out as soon as it had been taken. Irritability and screaming attacks developed, and the neck seemed to be stiff. She made no effort to sit up or raise her head, and no interest was taken in her surroundings. On admission, at the age of 12 months, the child was found to be exceedingly irritable and miserable, with a profuse, purulent nasal discharge. The latter was examined for Klebs-Loeffler bacilli, but only staphylococci were cultured. In general she lay quietly curled up in her cot away from the light, but she screamed if anyone went near her. Sleep was fitful and disturbed, but hypnotics were not needed. There was slight irregular fever as in Case 1, and the tachycardia was even more marked (100–180), the sleeping pulse being 100. Because of the history and general clinical aspect a provisional diagnosis of tuberculous meningitis was made, but no demonstrable change existed in the cerebro-spinal fluid. After two weeks of observation the child was worse, she had lost weight, her muscles were extremely wasted and flabby, and the tachycardia was as persistent as ever, when one day she was seen to be rubbing her hands and feet together as though they itched. At this time there was no rash or change in the appearance of the hands and feet, but later a fine papular rash appeared on the trunk and this became persistently clammy. The palms of the hands also took on a sodden appearance and the rubbing movements continued. Stomatitis appeared, the buccal mucosa being red and ulcerated. The blood-pressure was taken at this time and found to be raised—140/100. She remained in much the same state, at times gaining weight and then losing her gain with disappointing rapidity. Three months after admission, at the age of 15 months, she weighed only 17 lb. 8 oz., and was so weak that if placed with her head between her knees, she remained helpless, unable to move. For some weeks the knee-jerks were not obtained, but they soon reappeared, while no change

was demonstrated in the response to pin-prick. Finally, five months after admission, she began to take her feeds better, her muscles slowly became firmer and stronger, and she sat up and took an interest in her surroundings. Even on discharge she was still rather irritable and difficult to feed. Special investigations during the period of observation revealed a normal blood picture and serum calcium, a negative Wassermann reaction, a normal electrocardiogram (apart from sinus tachycardia), but a definitely raised sedimentation rate (21 millimetres instead of the normal 10 millimetres).

Here, then, is a case which presented at one time or another all the features of pink disease, though the hands and feet were never pink or anaesthetic. Yet the course of the disease leaves little doubt that this case was one of pink disease.

To summarize the clinical features, there is first and foremost the characteristic mental attitude of misery and irritability, while photophobia and insomnia are often present. There is muscular weakness and hypotonia, often with absent tendon reflexes. The hands, feet and nose are pink and appear to irritate, while areas of anaesthesia may be demonstrated on the limbs. There is constant anorexia with stomatitis, and perhaps periods of diarrhoea and vomiting. Tachycardia, frequently hyperpnea, an irregular fever of low grade, marked sweating resulting in a mousy odour, a fine papular eruption and nasal discharge complete the list. In the blood a polymorphonuclear leucocytosis may be present.

Finally, the long course of the illness, with its many ups and downs, usually with eventual recovery, but sometimes sudden death or death from bronchopneumonia, or enteritis, complete the clinical aspect of this disease.

MORBID ANATOMY AND AETIOLOGY.

Paterson and Greenfield (1), in a description of two fatal cases, demonstrated that pink disease is essentially a disease of the nervous system. There is a demyelination of the peripheral nerves, a chromatolysis of the anterior horn-cells of the lumbar and cervical enlargements of the cord, and a small-celled infiltration of the grey matter of the cord. Wyllie and Stern (2), with seven fatal cases, have confirmed these findings. In one of their cases, dying suddenly after only a short illness, there was a demyelination of the vagus. They were unable to demonstrate any constant change in the brain. Francioni and Vigi (3) claimed to have discovered lesions in the sympathetic system, but their case also showed lesions typical of epidemic encephalitis.

Other authors, notably Lereboullet (4), claim that there is definite evidence of an encephalitis involving especially the subthalamus and so causing an upset of the sympathetic system. It may be accepted that there is a peripheral neuritis and a myelitis in pink disease, though whether there is an encephalitis or not is yet

unproved. A dysfunction of the sympathetic system is a convenient explanation of the trophic changes, which are such a feature of this disorder.

To embark on a consideration of the aetiology at once leads into the realm of theory. Of the chief theories, the infective one, which implies infection with a neurotic virus, is most widely accepted at present. The nasal discharge suggests a localization of the site of invasion to the nose or nasopharynx, which is known to be the site favoured by other neurotropic viruses, notably poliomyelitis and epidemic encephalitis. Other features supporting an infective origin are the fever, the tachycardia and the polymorphonuclear leucocytosis. The raised sedimentation rate in Case 2 may be noted in passing.

The other main theory is the nutritional one. This theory originated in Findlay and Stern's (5) work on a nutritional disorder of rats characterized by epidermal changes and produced by feeding on egg-white. If pink disease is a deficiency disease, then the deficient factor is not one of any of the factors at present recognized as necessary for normal nutrition. Pellagra is somewhat like pink disease in presenting a combination of alimentary, nervous and integumentary symptoms, but there are many differences, of which one most striking is the lack of excessive pigmentation in pink disease. Of the other views which have been put forward from time to time none bear scrutiny. The recent suggestion by Braithwaite (6) that excessive exposure to ultra-violet light is concerned in the aetiology is counterbalanced by the favourable results reported by other observers (Sweet (7)) of treatment with ultra-violet light irradiation.

TREATMENT.

With the inadequate knowledge possessed at present of the nature of this disease treatment can only be empirical. The best that can be done is to promote an adequate calorie and vitamin intake, and because of the anorexia and irritability, this depends greatly on the nursing of the infant. Thus, Case 2 would take her bottle quite well after some few weeks in the ward, but required much persuasion, and she utterly refused to take from strangers. In addition to the milk feeds usual at this age, radiostoleum, bemax and orange-juice should be given to supply the necessary vitamins. Liver extract was administered for a prolonged period to Case 2, without any beneficial effect being observed (Wyllie and Stern (2) have claimed good results with raw liver).

Both the cases reported were given blood transfusions, with benefit in Case 1, but without marked effect in Case 2.

CONCLUSIONS.

This brief account of pink disease is promoted by the belief that cases of this disorder are frequently missed, and that only acquaintance with the variable clinical picture will lead to more accurate diagnosis. Further observation and experiment is still necessary before a rational therapy can be instituted.

My thanks are due to Dr. Charles F. Harris for permission to publish the two cases.

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THE MAN WHO WAS NEARLY A DOCTOR.

(With apologies to Bernard Darwin.)

THE blackness and horror of the east wind had given place to the warmth of a summer. The rampagousness of the elements no more provided the excuse for an evening by a large and cheerful fire, with a novel as his first choice and *Aids to Pathology* as his second.

So he turned once again towards Damocles—or a Board of Examiners and Pathology—and struggled to get ready once more. He knew they would show him a bottle, and he had piously resigned himself to prepare for it by pursuing with iron self-control the series of specimens that belonged to the teaching collection. He glimpsed just waywardly at the array of victim examples of this and that, which were to pass for ever with the dust of the week's spring-cleaning in the Museum. He would have liked to eye them for the last time, partly for the satisfaction of knowing that he

need not interpret them, and partly because they could never be used by the enemy, if only because the enemy, like everyone else, would surely have mistaken their identity.

Perchance they would show him also the difficulties of the unknown down a microscope, and he had learnt to his cost already that it was better to describe what he saw, unwitting as he was of its nature, than to imagine he could tell what it was and describe, as he thought, its appearance—because he was a "chronic" by now, and one of those really unlucky people against whom one can only suppose that the enemy had a personal spite. And it worried him more than a little, because the end was quite nearly in sight. He had only to win just once and then he could rest content. He had only to prove once again to that Board that they could start by assuming him to be a zany, but end by discovering he was not.

He had dreamt, before the last encounter in medicine, more than once of a figure—lordotic perhaps—which inquired, "Precisely what do you mean by some medicine for his cough?" He had learnt to spell, even in Latin; he had versed himself in the ghastly and scurrilous procedures for which he might be assailed, if ever he got into practice. And this time he had much less to do; but the gunpowder of his enthusiasm had almost run out of the heels of his boots.

And then the great day came, and for the first few moments there came from his lips a flow of eloquent wisdom that made the enemy wonder how it was possible from such a decrepit frame. But the storm was to follow—and bottles and slides, as usual quite unlike anything he had ever beheld. Nevertheless he weathered it, and the bell was nearly upon him when the last chance came. He had to look down the microscope once again, but this time, for a change, he knew what it was; and with the courage of his convictions he triumphantly declared carcinoma. . . . But what was a carcinoma? And of what? . . . And he muttered and stared; but still he didn't just know. So Greek was the stumbling-block this time, but, of course, he had never been privileged to learn it at school. "Precisely what do you mean by the word carcinoma?" was all he heard before the bell rang clearly and as dramatically as if it summoned him like King Duncan's knell. He walked out into the street, and there was a crowd collected round the victim of a motoring accident. . . . Was there a doctor in the crowd, someone asked? But then he could stand no more; so he turned quickly away, and muttered to himself as consolation, "But what is victory or defeat compared with education?"

"FLETCHER."

OVARIAN TERATOMATA: A REPORT OF THREE UNUSUAL CASES.



TERATOMA of the ovary may be either cystic, in which case it is commonly referred to as a "dermoid cyst", or solid.

The cystic teratomata are innocent tumours, forming about 10% of all ovarian cysts. A dermoid process, projecting into the cavity of the cyst, is the centre of activity of the tumour, often containing tissues representative of all three embryonic cell layers, and is thus truly teratomatous, being an abortive attempt at the

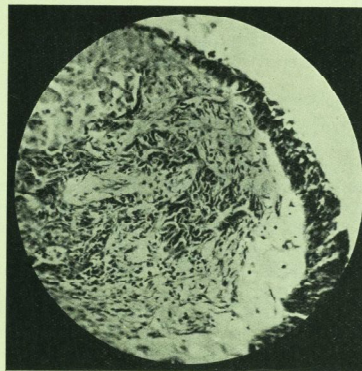


FIG. 1. $\times 125$.

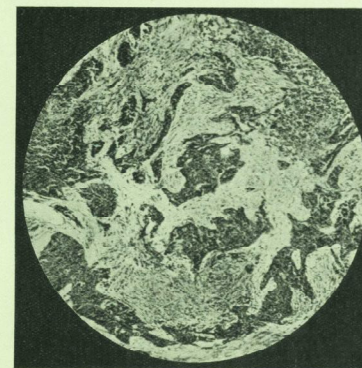


FIG. 2. $\times 60$.

formation of the cephalic extremity of the embryo (1). Bland-Sutton (2) suggests that these tumours might be not inaptly called "fatherless embryos". In rare cases a malignant change develops in one of the tissue elements of the dermoid process (Case 1).

The solid teratomata are rare tumours, considered by most pathologists to be primarily malignant (Cases 2 and 3).

CASE 1.—Squamous-celled Carcinoma Developing in a "Dermoid Cyst" of the Ovary.

A housewife, *et. 50*, who first came to St. Bartholomew's Hospital on November 29th, 1933, complaining of "difficulty in passing her water".

Menstrual history.—Regular periods until the menopause fourteen years ago.

Obstetrical history.—One pregnancy, with a living full-term child, nineteen years ago.

History of present condition.—Three to four months' increasing abdominal enlargement. Six weeks' delay in starting micturition, with pain and a poor flow of urine; symptoms becoming progressively

worse. No increased frequency of micturition and no incontinence. Gradual onset of constipation. No abdominal pain; no vaginal discharge.

On examination.—Thin, ill-looking woman. Abdomen: Visible distension of hypogastrium. Palpable cystic swelling rising out of the pelvis to within about 2 in. of the umbilicus, with a more solid portion to the left. Well defined, fixed and not tender. No ascites and no other viscus palpable.

Vaginal examination.—Cervix lay high up and displaced forward. Uterus displaced to the left; enlarged to twice normal size and fixed. Fixed, cystic swelling to the right of the uterus and extending into the pouch of Douglas. No nodules palpable. There was no oedema of the legs. Urine: Nothing abnormal discovered.

Diagnosis.—Malignant ovarian cyst.

Operation, December 14th, 1933, by Dr. Wilfred Shaw, under gas, oxygen and ether anaesthesia. Low left paramedian incision. A large, lobulated, cystic tumour filled the pelvis. It was fixed to the back of the uterus and extended to the right side of the pouch of Douglas. Anteriorly the bladder was adherent, but was easily stripped off.

Panhysterectomy was performed, and the cyst removed whole, together with the uterus. A mass of friable necrotic tissue infiltrating the uterus partly tore through during the removal. No nodules could be felt in the abdomen.

Convalescence was uninterrupted.

Deep X-ray therapy, January 1st to 19th, 1934. Sixteen doses in all through anterior and posterior fields. 200% of unit skin dose, equivalent to one erythema dose over the period stated. Rays were produced by 200 kilovolts and filtered by a Thorax filter.

Further progress, March 15th (three months after operation).—Patient felt well. Weight was about stationary. No micturition symptoms. Good scar. No evidence of recurrence.

Pathology.—The specimen removed at operation consisted of a large cyst, 8 in. by 8 in., adherent by a mass of friable tissue to the posterior aspect of the uterus; the lower half of the uterus and the right tube and ovary appeared normal.

The cyst contained sebaceous material and hair. It was thin-walled, except for several papillary processes projecting from one area into the cyst cavity. One of these processes was friable and continuous with the necrotic tissue invading the uterus.

Histology.—A squamous-celled carcinoma developing from the squamous-cell lining of the cyst (Fig. 1), and infiltrating the connective-tissue stroma of the cyst-wall and the back of the body of the uterus. There was much necrosis in the central areas of growth (Fig. 2).

CASE 2.—Solid Teratoma in the Wall of a Pseudomucinous Cyst.

Married woman, *æt.* 34, admitted to St. Bartholomew's Hospital on February 12th, 1934, complaining of pain in the left side and swelling of the abdomen.

Menstrual history.—Regular periods every month, lasting three days, commencing at the age of 17. No pain.

Obstetrical history.—Two pregnancies: (1) 6½ months, stillborn; (2) normal four years ago; child alive and well.

History of present condition.—Five weeks' increasing enlargement of abdomen. Three weeks' gnawing pain in left side. No vaginal discharge. Feels well herself. Micturition natural. Bowels open regularly.

Past history.—1922: W.R. ++++. 1930: W.R. —.

On examination.—Healthy-looking woman. Abdomen: Generally distended, especially below umbilicus. Swelling arising from pelvis; cystic, with harder areas, tender; resonant in flanks. No viscera felt. No œdema of legs.

Vaginal examination.—Cervix is high, looking downwards and backwards, softened and patulous. The swelling is not continuous with the cervix. Urine: Nothing abnormal discovered.

X-ray showed a large swelling in the mid-line of the lower abdomen, displacing the intestines upwards and posteriorly. Numerous areas of calcification were seen in the swelling, some of which could represent dental elements.

Diagnosis.—Dermoid cyst.

Operation, February 14th, 1934, by Mr. Beattie, under general anaesthesia. A large cyst was found to have burrowed between the layers of the broad ligament. There was considerable difficulty in separating it. The cyst was aspirated and removed whole.

Convalescence was uncomplicated, and the patient was discharged on March 3rd.

Pathology.—The tumour consisted of a multilocular pseudomucinous cyst, in one area of which was situated a partly solid, partly cystic mass, amongst which hair, teeth and pieces of bone could be identified. The solid irregular mass measured about 6 in. across.

Histology.—Epithelial structures, forming multiple small cysts and glandular acini and areas of cartilage, lay in a cellular connective-tissue stroma. There was no evidence of malignancy.

CASE 3.—Solid Teratoma.

Girl, *æt.* 12, was admitted to St. Bartholomew's Hospital on March 16th, 1934, complaining of a painful lump in her abdomen. She had never menstruated.

History of the present condition.—One week, lump in her abdomen, not noticeably growing in size. Six days' pain in the abdomen, with occasional sharp exacerbations; not severe. Micturition was natural and bowels opened regularly. General health good; played games at school.

On examination.—Rather pale, but healthy-looking girl. Abdomen: Visible swelling in mid-line below umbilicus; no rigidity; no tenderness. Palpable pear-shaped swelling rising out of the pelvis, reaching to the umbilicus, about 4 in. in diameter: firm, smooth and solid; mobile laterally, but not vertically. No viscera palpable.

Rectal examination.—Cervix high up and hard. The swelling moved apart from the cervix. Small uterus loosely attached to the under-surface of the tumour. Urine: Nothing abnormal found. No œdema of the legs.

Operation, March 20th, 1934, by Mr. Beattie, under gas, oxygen and ether anaesthesia. Left sub-umbilical paramedian incision.

The tumour, which filled the lower abdomen, was found to be solid. It was adherent by some old blood-clot to the rectum, but was easily removed whole. The right ovary appeared normal.

Convalescence was uncomplicated, and patient was discharged on April 7th, 1934.

Pathology.—The tumour consisted of a spherical mass, 4 in. in diameter, which was honey-combed in appearance and contained fragments of bone and cartilage.

Histology.—Epiblastic and mesoblastic tissues were recognized, but there was no evidence of malignancy.

It is interesting to note that in both Cases 2 and 3 the history is a short one, especially in Case 3, yet the tumours were large in size. In neither of these cases was there any histological evidence of malignancy.

COMMENT.

The development of malignancy in a dermoid cyst of the ovary occurs in from 0.5 to 5.0% (3) of cases, only those being considered in which the change actually began in one of the tissue elements of the dermoid cyst itself. Although squamous-celled carcinoma is by far the commonest type, adenocarcinoma, sarcoma and endothelioma have been described.

In 1928 Masson and Ochsenhirt (3) reviewed the literature, and could find only 33 authentic cases of squamous-celled carcinoma arising primarily in a dermoid cyst of the ovary; to these they added 3 cases of their own. More recently cases have been reported by Deaver (4), Tedenat (5) and others (6), one of which (6) was remarkable for the very rapid and widespread dissemination. One specimen from a recent case is in the Museum of the Royal College of Surgeons (No. 8383 i).

The age of onset varies from 20 to 66 years, with an average of about 49 years. The symptoms are not typical, but pain, rather rapid abdominal swelling and micturition dysfunction are the most common.

Unfortunately the prognosis is grave, and death usually follows within two or three years of operation. Cases of five years' survival and of death from metastases after seven years are reported (3, 5).

The association of dermoid cysts with pseudomucinous cysts of the ovary is well known, but the combination of a solid teratoma and a pseudomucinous cystadenoma must be very uncommon. It has been suggested (7) that the two cysts "formed part of an original tumour", and that one area of the dermoid differentiated itself into a pseudomucinous cyst. It is interesting to note, therefore, that in Case 2, a histologically innocent but solid teratoma grew in the wall of a pseudomucinous cyst. In fact this case appears to link up the cystic and solid teratomata, combining some of the chief characteristics of each.

Bland Sutton's description of solid teratomata can hardly be bettered: "Malignant ovarian teratomata occur in girls and young women as solid or semi-solid tumours, and rarely attract attention until an increase in the size of the abdomen is noticed by the patient or her relatives. The tumour grows quickly, disseminates like cancer, recurs very rapidly after removal, and destroys life in a few weeks or months." Recurrence and dissemination may take various forms; either the whole teratoma is malignant, giving rise to metastases of mixed tissues, or one type of cell only is malignant, giving rise to carcinomatous or sarcomatous metastases, usually the latter (8).

The prognosis is probably not always as hopeless as

Bland-Sutton suggests. Shaw (7) has reported a case well after five years, and quotes figures giving a four-year survival-rate of 25%. He examined four specimens of solid teratoma, of which only two showed signs of malignancy, in each case taking the form of a sarcoma. Recently Sarma (9) has reviewed the literature, and reported the case of a patient, *æt.* 5, who died with extensive metastases and local recurrence seventeen months after the removal of an encapsulated tumour. He came to the conclusion that all solid teratomata should be regarded as potentially malignant, even if histologically innocent.

I am greatly indebted to Dr. Wilfred Shaw and to Mr. Beattie for their permission to publish these cases, and wish to thank them for their assistance.

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TESTICULAR TERATOMA: A REPORT OF AN UNUSUAL CASE.

"I see thee what thou art,
For thou, the latest left of all my knights,
In whom should meet the offices of all,
Thou would'st betray me."

Tennyson, "Morte D'Arthur".

JUSTIFICATION for recording this single case of a surgical condition so well recognized as new growth of the testicle,* lies in the occurrence of the unexpected at every stage of its history.

The patient, a married man, *æt.* 33, employed as a clerk, was admitted to Percival Pott Ward on January 27th, 1934, complaining of swelling of the left testicle.

* The average number of cases of malignant disease of the testicle admitted to this hospital between 1923-33 has been six each year.

The patient's general physical and mental development had been perfectly normal. Until eight years ago, when he was 25 years of age, both testicles had remained in the inguinal canals beneath the superficial inguinal rings, and the right one had always been considerably smaller than the left. The left testis, then, over an uncertain period of months, descended spontaneously and completely into the scrotal sac. Six years ago the patient began a healthy and normal male child; three and a half years ago the condition of the left testis was recorded as being normal. No other relevant incident occurred until five months ago, when he first noticed a painless swelling of the left testicle; two months ago he commenced to have a dull continuous ache at the neck of the scrotum on the left, and wore a suspensory bandage, which afforded some relief; the swelling gradually increased in size, and two weeks ago, when attending in the Follow-up Department of this Hospital after partial thyroidectomy, he called attention to the scrotal swelling. He had no cough, loss of appetite, abdominal discomfort, or symptoms referable to organic disease of the nervous system; his weight had shown a steady increase during the past three years.

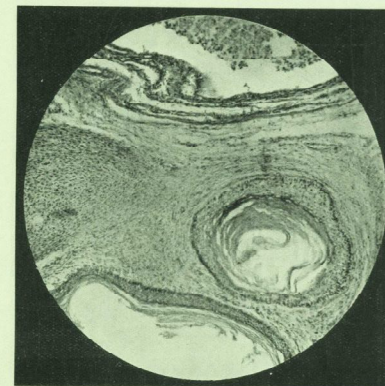


FIG. 1.—SECTION OF THE TUMOUR, SHOWING EPITHELIAL PEARL, SPINDLE-CELL STROMA AND SQUAMOUS-CELL CYST.

Additional past history was that he had first noticed symptoms of a diffuse toxic goitre six years ago, and the condition was treated three and a half years ago at this Hospital by a two-stage partial thyroidectomy; his general health returned to normal, and he was able to indulge in strenuous exercise, and his exophthalmos diminished considerably. There was no history indicative of venereal or tuberculous disease.

He was a well-built man, with a healthy complexion; his mental activity and distribution of body hair and fat was normal. General examination revealed no abnormality beyond slight prominence of the eyes and a mild degree of dental sepsis; his mucous membranes were of a good colour.

The local condition.—On the right side the scrotum was empty; the testis lay beneath the superficial inguinal ring, was of normal consistency, smaller than the normal adult testis, and testicular sensation could be elicited; the testis could not be displaced into the scrotum. Coughing revealed an abnormal impulse passing downwards and inwards along the canal to the neck of the scrotum, and easily controlled by one finger placed over the internal ring.

On the left side the skin of the scrotum was red, and the scrotal sac was occupied by an oval swelling about 3½ × 1½ × 2 in., with its long axis perpendicular; the scrotal skin was freely movable over the swelling. The swelling itself was not tender, and had a smooth surface and firm consistency; it was well defined, and did not extend into the neck of the scrotum; fluctuation could be elicited on some parts of its surface only, but it was not translucent; testicular sensation was absent. The epididymis could not be

clearly distinguished. The spermatic cord was thickened, but its individual constituents could not be defined; an impulse, similar to that on the right side, was present on coughing, and extended into the neck of the scrotum.

Rectal examination revealed a normal prostate; there was no palpable abdominal tumour, no supraclavicular lymphatic gland enlargement and no indication of neoplastic metastasis elsewhere. The breasts were not enlarged.

A diagnosis of testicular neoplasm was made, and left orchidectomy was performed on January 30th, the contents of the left side of the scrotum were removed, together with the cord and patent funicular process, and the patient was discharged with the wound completely healed on February 14th; convalescence has since been uneventful, and the patient has returned to normal work.

Pathology.—The parietal and visceral layers of the tunica vaginalis were adherent in several places, and the vaginal sac contained a small amount of clear fluid. The tumour was well defined and the epididymis was distinct and separate, the sinus epididymis being

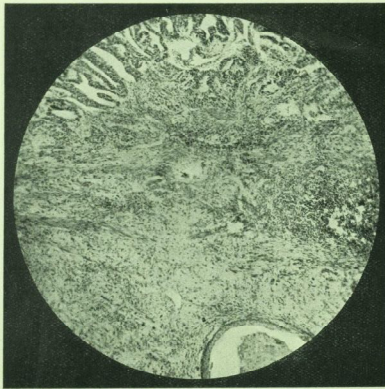


FIG. 2.—SECTION OF THE TUMOUR, SHOWING SMOOTH MUSCLE IN SPINDLE-CELL STROMA, AND COLUMNAR EPITHELIUM WITH MALIGNANT PROLIFERATION.

well marked. The surface of the tumour was smooth, and covered by a network of dilated veins; local fluctuation could be elicited at several places on the surface, but the general consistency was firm; the cut surface bulged from the encapsulating tunica albuginea, which was somewhat thickened; there was no evident remaining testicular tissue, but it was replaced by a lobulated tumour, each lobule consisting of a heterogeneous cream-coloured tissue with a fibrous stroma; there were numerous cysts, the largest being $\frac{1}{4}$ in. in diameter; these cysts had opaque glistening walls and contained a gelatinous substance; there were also, scattered irregularly in the tumour, numerous hard, white bodies about 1 mm. diameter. Towards the posterior border of the tumour were several soft haemorrhagic areas. There was lymphatic thickening in the cord, but no macroscopic deposit of growth.

Microscopic section showed that the bulk of the tumour consisted of spindle-shaped cells, with large hyperchromatic nuclei, and many blood-channels whose walls were devoid of epithelial lining, being formed merely by tumour-cells. Embedded in this stroma were smooth muscle-fibres, hyaline cartilage and epithelial pearls; there were also many cystic spaces lined by cubical or columnar epithelium. The tumour was thus triphyllic, there being elements derived from all three embryonal layers; both epithelial and mesoblastic elements exhibited malignant proliferation. There was no evidence of chorionic epitheliomatous tissue, the presence of which was suggested macroscopically by the haemorrhagic areas, and the Asheim-Zondek test was negative.

Pathological classification: Cairns (1), who regards all testicular neoplasms as teratomatous, in that they are derived from totipotent cells, whether isolated blastomeres or spermatocytes, classifies these neoplasms in five groups: (i) *Typical teratoma* (testicular dermoid), the main mass of which is a dermoid cyst containing sebaceous material, hairs, etc., and including in its wall a small embryonal element composed of various tridermal derivatives; (ii) *atypical teratoma*, which consists of a heterogeneous collection of differentiated and undifferentiated derivatives of all three layers, intimately mixed together; (iii) *chorion carcinoma*; (iv) *spheroidal-cell tumour* ("sérinome", "spermatocytoma") (2); and (v) *combined types*, consisting of well-defined areas of atypical teratoma and of spheroidal cell tumour.

The tumour under consideration here would be classified as an atypical teratoma.

Prognosis: This will depend upon the pathology of the tumour, and of the five groups, only the first, the "testicular dermoid", or typical teratoma, is benign; the atypical variety is characterized by a malignancy which may remain dormant for some time, either as primary or metastatic growth, and then flare up. The distant spread of these tumours may lead to simple "monophylic" or complex teratomatous metastases (3).

Treatment: Surgery consists of either local orchidectomy, as performed in this case, or radical excision, including the whole length of the cord and the lumbar glands; the latter is a formidable operation, with a high ultimate mortality. The response of these tumours to irradiation is again dependent on their pathology, and the results of deep X-ray therapy, at this Hospital and elsewhere (4), have been good; the spheroidal-cell and chorion-carcinoma types respond very readily indeed in primary and metastatic form, but the atypical variety is less sensitive, the degree of sensitivity varying with the embryonal layer from which the predominant tissue is derived, and very large dosage may be required. After orchidectomy, although there may be no obvious gland involvement, prophylactic deep X-ray therapy for the lumbar glands is considered advisable, as recurrence otherwise appears to occur within one year.

COMMENTS.

The imperfectly descended testis has been the subject of innumerable monographs during recent decades, and it was the subject of the Hunterian Lecture in 1902 (5). Malignant disease of the testis has similarly been the centre of much discussion, and was the subject of the Hunterian Lecture in 1926 (1). The reputed tendency of the imperfectly descended testicle to undergo neoplastic change has likewise been a bone of contention, well chewed in every medical course, textbook and

monograph, on either imperfect descent or malignant disease of the male gonad, this bone, however, appears to have been laid aside, temporarily at any rate, by Russell Howard (6), who, after considerable experience in the matter, declares that the imperfectly descended organ has no special tendency to neoplastic change.

The spontaneous completion of descent of the testis is said to be extremely rare after the age of puberty.

In the matter of spermatogenesis there is also considerable debate, but it is generally accepted that if a testicle is not in the scrotum by puberty, it will not acquire the power of producing live spermatozoa, while some authorities hold that it must be brought into the scrotum within the first five years of life.

Internal secretion used to be considered unlikely in imperfectly descended testes, which were also abnormally small, but it is now said to be possible for a testis, even if it be undersized, to contain interstitial tissue in sufficient quantity to enable normal physical and mental development to take place, in the absence of a normal testis on the other side.

A further relevant point is the occurrence of a patent funicular process in cases of imperfect descent; this appears to be so in 75% of cases.

This case seems, then, to illustrate several of the rarer possibilities in the history of imperfect descent of the testis. The condition was bilateral, the right testis being abnormally small; the left and normal-sized organ completed its descent spontaneously into the scrotum at the age of 25, and at the age of 27 was then apparently responsible for spermatogenesis (the onset of toxic goitre at this point is of interest); at the age of 33, eight years after its descent was complete, malignant change became evident, though it is impossible to say how long the actual neoplastic process had been going on, especially as the rate of growth of this "atypical" variety is very variable. In this case both funicular processes were patent. The subsequent destruction of testicular tissue and final operative removal have produced no obvious change in the physical or mental metabolism of the patient; further changes may, however, be marked by metastatic recurrence of the disease process.

In conclusion, one may say, the imperfectly descended testis is very vague as to its future course.

My thanks are due to Professor Gask for permission to publish this case-report.

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D. F. ELLISON NASH.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. OLD PAULINES.

Played at Winchmore Hill on Saturday, February 17th. Won, 25—3.

The Hospital, fielding what might fairly be described as their strongest side, easily defeated the Old Paulines by the convincing margin of five goals to one try in a game which was productive of much bad scrummaging, some fine kicking by Morison and a display of resolute speed by Youngman, which drew from one spectator the breathless remark, "That's Youngman, that was".

The marked superiority of the Hospital, though a pleasing phenomenon to the partisan, detracted somewhat from the excitement of the game, which, especially during the first half, was exceptionally uninteresting. Full credit is due to the fine work of forwards and backs alike, but our heavy score was in a large part due to the lack of "covering" and to the poor defence of our opponents.

Late in the first half Fairlie Clarke scored the first try, rounding off a movement which commenced with Wilson and passed through at least seven players' hands—a combined effort which fully merited its reward.

A drop-kick from Kingdon soared away narrowly to fail; Nel and Blusger in turn on one wing, and Youngman on the other, were pulled down on the line, Wilson kicked twice for touch, scored a determined try, and Bart's crossed over with a 10-point lead.

For the first few minutes of the second half the Old Paulines struggled hard and a score seemed imminent, but the Hospital defence proved more than adequate, the ball eventually being worked up the field in forward rushes by a well-controlled pack.

Two tries by Youngman followed in rapid succession; receiving the ball on the half-way line on each occasion, he outdistanced every player on the field, swerving past the full back and giving Morison the chance to kick two more goals. A minute later he caught the full-back in possession and kicked the ball over the line, where Jackson, narrowly preceding a Pauline defender, threw himself on it. Morison kicked his fifth consecutive goal.

Shortly after, Sidmou cut through and gave the ball to Nicholls, who scored the Old Paulines' only try, which Schmetsson failed to convert.

Team.—C. R. Morison (back); J. G. Youngman, G. A. Fairlie-Clarke, I. N. Blusger, J. G. Nel (three-quarters); J. R. Kingdon, J. D. Wilson (halves); E. M. Darmady, R. S. Hunt, P. D. Swinthead, J. M. Jackson, E. E. Harris, J. C. Newbold, W. M. Capper, R. Mundy (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. DEVONPORT SERVICES.

This match was played at Winchmore Hill on Saturday, March 10th, and was lost by 2 tries (6 pts.) to nil.

Severe rain and a severe hailstorm almost ruined this game. It was chiefly a forward game, with the Services' heavier pack having somewhat the better of the struggle.

Both tries were scored in the early part of the game before the conditions became almost impossible for handling. Evans intercepted a pass between our centres, ran hard, and then passed to

Kirby to Kirby in the corner. The try was not converted. Soon afterwards Kirby again scored in the corner, rounding off a good three-quarter movement. The attempt at conversion failed. Bart's, together with the weather, improved considerably in the second half, and attacked continuously, and it was only the superb defence of the Services that prevented our scoring. Youngman had very hard luck in not scoring twice, being brought down on the line on each occasion. Our pack were now holding their own in the tight and the loose, and playing very well. Morison was in very good form, and his kicking had great length. The game ended with Bart's still on the attack. We were perhaps rather unlucky in not having made the game a draw after our splendid second-half recovery.

HOCKEY CLUB.

Semi-Final Inter-Hospital Cup.

ST. BARTHOLOMEW'S HOSPITAL v. KING'S COLLEGE HOSPITAL.

Played on Wednesday, February 28th. Lost, 0-1. Bart's were unfortunate in that through injuries they were fielding a much weakened side. The game, however, was an exceedingly good one, and all, including the substitutes, played as well as at any time this season. Masina, brought in to partner Thorne-Thorne at back, was always dependable, clearing to the wings with precision; while Heasman, playing in the unaccustomed position of left half, worked, as usual, tremendously hard. The forward line managed a very much more open game than usual, and given a little more dash might have scored on several occasions.

Play started with a dting-dong struggle, which at first was to give neither side the advantage, though Hinds-Howell was unlucky with a hard shot which just cleared the cross-bar. Hill made some good runs down his wing, and one or two resulting corners proved fruitless. Half-time arrived with no goals scored.

Following half-time, however, King's College Hospital broke away once and, through a fast inside left, drew Crosse out of goal and scored with a clever bit of dribbling. Though Bart's played with redoubled vigour, they were unable to equalize.

Team.—J. M. Crosse (goal); B. Thorne-Thorne, A. M. Masina (backs); P. Jayes, J. R. Winter, L. Heasman (halves); P. G. Hill, A. Hinds-Howell, K. W. Martin, K. Lumsden, J. M. Lockett (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. READING UNIVERSITY.

Played on Saturday, March 10th. Lost, 3-2.

The game was a fitting close to the season, being both spirited and exciting. With a team half composed of the second eleven, Bart's yet led an unbeaten side by two goals for the major part of the first half. Crosse in goal was particularly conspicuous, saving repeatedly with brilliance; Masina at centre half worked hard, and Sharpe, Blackburn and Lockett formed a wing which was often within inches of scoring.

Play started briskly, and Bart's, adopting the hard-hitting, open game, very soon scored through Sharpe, from a short corner—a beautifully cool and hard shot taken from an awkward pass. The Hospital circle was then raided, and only Crosse's brilliance stopped Reading from scoring. Later Blackburn dribbled through to score for the Hospital, a score which was answered just before half-time by Reading (2-1).

The second half started disastrously, for Reading snapped up two quick goals (2-3). From thence till time both sides strove desperately, the one to equalize, the other to maintain their lead. Sharpe and Blackburn were particularly conspicuous in a team which to a man were playing very hard; the latter seeing one of his shots bounce off the post and travel the whole length of the goal-line. The whistle was blown for time with no alteration in the score.

Team.—J. M. Crosse (goal); B. Thorne-Thorne, P. M. Wright (backs); P. Jayes, A. M. Masina, C. F. Maddox (halves); P. G. Hill, A. Innes, A. E. Sharpe, G. Blackburn, J. M. Lockett (forwards).

BOXING CLUB.

The United Hospitals Boxing Competition was held at The Ring, Blackfriars, on Monday, March 12th, and resulted in an overwhelming victory for Bart's. Six of the eight weights fell to the team, who scored 34 points to the 17 points of Mary's, who were second.

St. Bartholomew's drew first blood with the first fight of the evening, in which Moseby beat Lewis of Guy's fairly easily. Lewis is an experienced man, but Moseby's speed and weight were too much for him.

Bose had a very close fight with Griffiths of St. Thomas's, who was his most serious contender for the bantam weight title, and the issue was in doubt till the end. Bose, however, was more accurate in his hitting; he scored well with both hands on the retreat, and secured the verdict without recourse to the referee.

Fyssh disposed of Leach of St. Mary's before the first round was half way through by a series of beautifully-timed body punches.

Slove put up a good display in beating Gill of St. Thomas's. His opponent was very strong, and in the first round Slove made the mistake of trying to "mix it" with him—getting the worst of it. Early in the second round he "shook" his man by two quick right counters and outclassed him for the rest of the round. The final round was very closely contested and was fought amidst rousing cheers, but Slove's ring-craft stood him in good stead and we secured the verdict.

Taylor lost a good fight to Warren of London. The latter is an experienced and clever boxer, with a very long reach, and Taylor was "giving away" nearly a stone in weight. All the same, Taylor put up a very good fight and got home some excellent right uppercuts. He should learn to be more aggressive and constructive in his boxing.

Kirkwood met Clarkson of Guy's in the semi final of the heavy weights. Clarkson has twice beaten him before, but this time Kirkwood made no mistake, and got home a series of terrific blows, the fight being stopped in the first round.

We were disappointed to find Butt with only one opponent between him and the flyweight title, but Wilson of St. Thomas's put up a very good show, and Butt had to bring out all his skill to defeat him.

In the final of the bantams Bose found himself against a very aggressive fighter in Herman of London Hospital, but scored cleverly and accurately with both hands on the retreat, and himself attacked whenever he got the chance. At the end of the second round he launched a whirlwind attack and had his man badly shaken; the fight was stopped after a virtual knock-out early in the final round.

David met Goliath in the final of the feathers, for Fyssh was opposed to a man of exceptional physique in E. W. Rees of St. Thomas's, who is 6 ft. in height and a strong, experienced boxer. Fyssh, however, took many heavy blows and then got inside Rees's defence to score freely with left hooks to the body and head. In the second round Rees tried to hold him off with his long left, but Fyssh feinted and wormed his way in, and served such a succession of telling blows that he knocked his man out before the round was half way through.

Moseby beat D. F. Rees of St. Thomas's in the semi-final of the light-weights. The fight was very closely contested, and the three rounds were fought at a great pace. Moseby, however, had the advantage in speed and lasted better in the final round.

The final of the light-weights produced one of the best fights of the evening. Moseby was opposed to Mayer of London, the Captain of the U.I.B.C. Mayer got in some stiff blows at close quarters in the first round, but towards the end of the round Moseby got the measure of his man, and scored well with straight lefts and a quick right cross. In the second round he used his left to advantage against a tiring opponent, and in the final round he added to the victory by a whirlwind two handed attack and knocked his man out.

Slove won the final of the welters on a walk-over from Lomax of Guy's, who had damaged his eye in a previous fight. Slove himself had damaged his right hand in training a week before, and in winning his gruelling semi-final fight fully deserved the walk-over title.

In the final of the light heavy-weights, Armstrong, who had had a walk-over in the semi-final, was opposed to Ross of St. Mary's, a very starchy boxer with a terrific punch in both hands. Armstrong, however, was very game and, although knocked down eight times in the first round, he continued to be full of aggression until the referee stopped the fight in favour of Ross.

The final triumph of the evening was Kirkwood's victory over Welper of St. Mary's in the final of the heavy-weights. He had the advantage of weight, but Welper is no mean boxer, and at the end of the second round a shrewd blow would have knocked either man out. Both, however, survived to fight the three rounds, and Kirkwood gained a well-merited decision on points.

The evening was a triumph for our trainer, Matt Wells, for we were the fittest team in the competition. Moseby, Fyssh, Slove and Bose were all considerably overweight for some weeks preceding the competition, and he brought them to the scales just inside their weights, whilst Moseby's victories in three very hard fights is a testimony to their fitness.

The only previous holders of titles are Butt and Slove. Three of this year's winners, Moseby, Fyssh and Bose, are entirely new to

the competition, whilst Kirkwood has at last received the reward of all the hard work he has put in at his boxing.

The following is a list of the results in the competition.

Fly-weight: Final—A. Butt (Bart's) (holder) beat D. R. Wilson (St. Thomas's) on points.

Bantam: Semi-final—C. F. Bose (Bart's) beat L. Griffiths (St. Thomas's) on points. Final—Bose beat H. Herman (London) on points.

Feather: Semi-final—T. G. Fyssh (Bart's) beat P. W. Leach (St. Mary's) in first round. Final—Fyssh beat E. W. Rees (St. Thomas's) in second round.

Light: 1st series—W. G. Moseby (Bart's) beat G. G. Lewis (Guy's) on points. Semi-final—Moseby beat D. F. Rees (St. Thomas's) on points. Final—Moseby beat S. G. Mayer (London) in 3rd round.

Welter: Semi-final—J. J. Slove (Bart's) (holder) beat H. W. Gill (St. Thomas's) on points. Final—Slove w.o., J. A. Lomax (Guy's) injured.

Middle: Semi-final—C. P. Warren (London) beat L. K. Taylor (Bart's) on points. Final—G. J. Ambrose (St. Mary's) beat Warren on points.

Light heavy: Final—R. W. Rees (St. Mary's) beat J. H. Armstrong (Bart's) in first round.

Heavy: Semi-final—R. M. Kirkwood (Bart's) beat P. W. Clarkson (Guy's) in first round. Final—Kirkwood beat C. Welper (St. Mary's) on points.

T. G. W.

REVIEWS.

DIABETES: REASONS AND RECIPES. By E. E. CLAXTON, M.B., B.S., and LUCY BURDEKIN. With a foreword by GEORGE LAM, M.D., F.R.C.P., F.R.C.P. (London: John Lane, The Bodley Head, 1933.) Pp. xvi + 188. 10 plates. Price 5s. net.

The frontispiece of this invaluable little book serves very well as a text for its message. It is a photograph of healthy looking Six-years-old taking a keen interest in injecting his own dose of insulin. The authors' endeavour is to remove the "poor diabetic" from that group where "the same breakfast is eaten every morning" to the one "with something different every day", into which two classes Dr. Graham divides mankind as he gives his blessing to the book. The patient need be pitted no longer as one fettered by restrictions and regarded as an invalid.

The *Reasons* explain in the clearest way the principles of diet and the methods of testing and injection. Enough is told of the disease to make the various steps rational to the patient, thus ensuring his co-operation in what otherwise would be a tedious discipline. The functions of insulin are carefully explained with the aid of illustrations which are models of technical photography. The chapter on diet is a simple description of the composition of foods and of the three methods of restricting the carbohydrate intake: a fixed carbohydrate allowance; a definite number of each of the food components; and thirdly, that based on Lawrence's "Line Ration Scheme" (a good copy of the scheme is reproduced). The principle of the book is summed up in a sentence: "It doesn't matter what you eat provided you know what the food contains, so that you can judge how much you may take." This section closes with some most practical answers to twenty of the questions which must constantly arise in the minds of those under treatment.

The remaining 120 pages give over two hundred and twenty *Recipes* of every description, with food-value tables and sample *Diets*. Each recipe is accompanied by its food value, based on the carbohydrate "portion" of 5 grammes. There is such a variety of pleasant dishes that, except for the preciseness of the quantities, the recipes might be those used by any cook. There is a useful list arranging the recipes into groups of different carbohydrate quantity, for use in making up a meal to the correct value.

The book is attractively produced, and the type is so chosen that points of importance stand out in clear emphasis. It is remarkable that it can be published at such a low cost. The language is for the layman, and is so pleasantly written that we are not surprised to see in answer to the question, "What are the most important points in treatment?" with two others, the reply, "Keep smiling". The authors have succeeded in their object of giving "enough recipes and cookery hints to satisfy the enthusiastic diabetic, and to entuse those who lack sufficient interest to work out their own salvation".

The book is certainly one to be given or, at the least, recommended to every diabetic by his friend and doctor.

CAJAL'S HISTOLOGY. (London: Baillière, Tindall & Cox, 1933.) 9 x 9 1/2. Pp. xiv + 738. Figs. 335. Price 40s.

For many years the brilliance of the Spanish school of histologists has shed a radiance over the subject which they have made their own. Outstanding in the school is S. Ramon-Cajal, who has acquired an international reputation. Any work on histology bearing this illustrious name is sure of an adequate welcome.

In Spain the medical student early acquires a sound knowledge of this important subject, and is next introduced to histo-pathology. He thus obtains a detailed knowledge of the body in health and disease, and functions of the various organs of the body in health and disease.

This work is a translation of Cajal's textbook for students, and we consider ourselves fortunate that his vivid teaching has become available for English-speaking students.

As would be expected, the section devoted to the histology of the nervous system is by far the best in the book. Every part of this system has been laid bare in the greatest detail. The illustrations in this section are illuminating, and give impressions which are lasting. This latter quality is valuable to the student of histology. The complicated mechanism of cellular division is discussed with great clarity, and details are given of the formation of the blood-cells, with helpful diagrams. A good deal of the book is elementary, and it was designedly written thus.

A useful section is appended on histological methods, together with a section on the preparation of materials.

The work is beautifully produced, and we give a high commendation.

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- KERSLEY, G. D., M.D., M.R.C.P. "Leaking Cerebral Aneurysm." *British Medical Journal*, March 3rd, 1934.
- KETTLE, E. H., M.D., F.R.C.P. "The Detection of Dangerous Dusts." *Lancet*, April 28th, 1934.
- LEVITT, W. M., M.D., M.R.C.P., D.M.R.E. "The Radium Treatment of Neoplasm, with Special Reference to the Relative Values of Hard and Soft Rays." *British Journal of Radiology*, March, 1934.
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- PARSONS, F. B., M.D., M.R.C.P. "Anesthesia in Labour: A Review of Modern Progress." *Practitioner*, March, 1934.
- PHILLIPS, J. G., PORTER, M.D., F.R.C.P. "Medico-Legal Problems in General Practice. III: The Medico-Legal Aspects of Mental Disorders." *Practitioner*, March, 1934.
- POWER, Sir D'ARCY, K.B.E., F.R.C.S. "Ipsissima Verba. I: Lister and Wiring the Patella." *British Journal of Surgery*, April, 1934.
- PYBUS, F. C., M.S., F.R.C.S. "A Case of Gas-cysts of the Intestine." *British Journal of Surgery*, January, 1934.
- RAY, P. N., F.R.C.S. "Spontaneous Dislocation of the Hip in Childhood." *British Journal of Surgery*, January, 1934.
- ROCHE, ALEX. E., M.D., M.Ch., F.R.C.S. "The Incompletely Descended Testicle." *Clinical Journal*, April, 1934.
- SCOTT, RONALD BODLEY, B.M., M.R.C.P. "Aneurysm of the Pulmonary Artery. With Report of a Case." *Lancet*, March 17th, 1934.
- SPARKS, J. V., M.R.C.S., D.M.R.E. "Paper Films in Radiography." *Lancet*, April 21st, 1934.
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- WALKER, KENNETH, M.B., F.R.C.S. "Sterility in the Male." *Practitioner*, March, 1934.
- WARD, R. OGIER, D.S.O., M.Ch., F.R.C.S. See Christopherson and Ward.
- WEBER, F. PARKES, M.D., F.R.C.P. "Transient Massive Albuminuria After Chromocystoscopy in a Psycho-Neurotic Individual." *British Medical Journal*, April 7th, 1934.
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- YOUNG, F. H., O.B.E., M.D., F.R.C.P., D.P.H. "Some Theoretical Aspects of Collapse Therapy." *British Medical Journal*, April 14th, 1934.

EXAMINATIONS, ETC.

University of London.

Second Examination for Medical Degrees, March, 1934.

Part I.—Allen, W. H. E., Ballantyne, J. C., Banaji, P. B., Bennett, D. L., Boatman, D. W., Brockbank, C. A., Brownlee, P. A. K., Burns, B., de Senneville, R., Dobree, J. H., Dunn, D. M., Edwards, J. A. C., Evill, C. C., Fagg, C. G., Frazer, A. L., Gollidge, N. H. H., Grossmark, S., Grunbaum, A., Hall, W. S., Harrison, G. J., Herson, R. N., Hudson, E. G., Ives, L. A., Jayes, P. H., Jones, E. C., Kemp, J. W. L., Kruatrachue, G., Little, A. W., McEwen, P. D. R., McMahon, R. J. H., Macrae, D. E., Morse, D. V., Parkinson, T., Peyton, H. N., Rees, H. N., Reilly, C. P. C., Staley, G. R., Stone, S. D., Swinestead, P. D., Terry, R. B., Vandy, K. W., Young, N. A. F.

Part II.—Acharya, B. S. S., Baker, F. J. S., Bateman, A. D., Baum, I. H., Blakelock, L. H., Brooker, A. E. W., Carpenter, M. A., Dubash, J. J., Ellis, R. H., Ennis, J. E., Fearnley, J. D. O., Foster, L., Goodrich, B. H., Hambly, E. H., Herbert, G., Hoadley, J., Jackson, H., Jenkins, S. T. H., Jordan, A., Longland, C. J., Lopez Garcia, L. J., McKane, T. O., Mountjoy, E. R., Pearce, H. A., Roualle, H. L. M., Stevenson, K. Y., Thomson, J. W., Thompson, R. W., White, R. A., Woddis, G. M.

CHANGES OF ADDRESS.

BURKE, Lt.-Col. G. T., I.M.S., c/o Messrs. Grindlay & Co., Ltd., 54, Parliament Street, S.W. 1 (from May 22nd till mid-October).
DUNDAS-GRANT, Sir JAMES, 5, Harley House, Upper Harley Street, N.W. 1. (Tel. Welbeck 1892.)

APPOINTMENT.

BRAMBRIDGE, C. V., M.V.O., B.Ch.(Cantab.), F.R.C.S.(Edin.), E.A.M.S., appointed Surgical Specialist, Kenya.

BIRTHS.

ANGEL.—On April 9th, 1934, at Penlea House, Launceston, Cornwall, to Dorothy, wife of Rowland Eric Angel—a son.
EDWARDS.—On February 25th, 1934, at 12, Godfrey Road, Newport, to Edith, wife of J. T. Rice Edwards—a son.
GOODWIN.—On April 21st, 1934, at Hangchow, China, to Sheelah and T. S. Goodwin, M.D.—a daughter.
LANGHORNE.—On April 16th, 1934, to Yvonne (née Jessop), wife of Douglas Alfred Langhorne—a son.
ORCHARD.—On April 8th, 1934, at 12A, Kensington Court Place, to Sheila, wife of Dr. Stuart Orchard—a son.

MARRIAGES.

BARBER—SYKES.—On April 21st, 1934, at the Parish Church, Orpington, by the Rev. T. Sedgwick, assisted by the Rev. S. Osborne, Vicar of Orpington, Stanley Ward, younger son of Dr. F. S. Barber, of Streatham, to Margaret Lesley, only child of Mr. and Mrs. Ernest Sykes, of Orpington.
SINCLAIR—PULESTON.—On April 21st, 1934, at Parish Church, Watford, Charles Gordon Sinclair, F.R.C.S., younger son of Mr. and Mrs. C. P. Sinclair, of Roxburgh, Bushey, to Margaret Gwendith, only daughter of Mr. and Mrs. P. E. Puleston, of Langholm, Watford.
TURNER—INGRAM.—On April 14th, 1934, at All Saints', Ennismore Gardens, by the Rev. H. M. Relton, D.D., assisted by the Rev. R. H. Streatfield, uncle of the bridegroom, Ronald E. S. Turner, second son of Mr. and Mrs. Cecil W. Turner, of 49, Cleveland Square, W. 2, to "Peggy", only daughter of the late John Ingram and Mrs. Ingram, of 6, Victoria Grove, Kensington.

DEATHS.

ADAMS.—On February 26th, 1934, Edna Sybil, beloved wife of Dr. F. N. Adams, of "Pendower", Crown Hill, Devon.
ANDERSON.—On April 7th, 1934, at Royal Masonic Hospital, W., Donald Drysdale Anderson, M.R.C.S., L.R.C.P., West African Medical Service, aged 37.
BROWN.—On April 8th, 1934, Frederick Nathaniel Brown, L.R.C.P., M.R.C.S., of Hale Cottage, Sandbanks Road, Parkstone, Dorset.
FERRE.—On March 30th, 1934, at Stone, Staffordshire, John Fifth Fernie, M.R.C.S., L.R.C.P., aged 61.
TANNER.—On April 12th, 1934, at Tanerod's Ford, Farnham, Surrey, Charles Edward Tanner, M.D., F.R.C.S., J.P., aged 73.

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: National 4444.

St. Bartholomew's Hospital



JOURNAL.

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

Vol. XLI.—No. 9.]

JUNE 1ST, 1934.

PRICE NINEPENCE.

CALENDAR.

Fri.,	June	1.—Medicine: Clinical Lecture by Lord Horder. Dr. Gow and Mr. Girling Ball on duty.
Sat.,		2.—Cricket Match v. Broadmoor. Away.
Mon.,		4.—Special Subject: Clinical Lecture by Mr. Just.
Tues.,		5.—Dr. Graham and Mr. Roberts on duty.
Wed.,		6.—Surgery: Clinical Lecture by Mr. Harold Wilson. Tennis: 2nd Round Cup Ties. St. Bartholomew's Hospital v. St. Mary's Hospital. Away.
Fri.,		8.—Medicine: Clinical Lecture by Dr. Hinds Howell. Prof. Fraser and Prof. Gask on duty.
Sat.,		9.—Cricket: Past v. Present. Home. Tennis: Past v. Present. Home.
Mon.,		11.—Special Subject: Clinical Lecture by Mr. Elmslie.
Tues.,		12.—Lord Horder and Sir Charles Gordon-Watson on duty.
Wed.,		13.—Surgery: Clinical Lecture by Mr. Roberts. Cricket Match v. Bedfordshire C.C.C. Away.
Fri.,		15.—Medicine: Clinical Lecture by Dr. Gow. Dr. Hinds Howell and Mr. Harold Wilson on duty.
Sat.,		16.—Cricket Match v. Hampstead. Home.
Mon.,		18.—Special Subject: Clinical Lecture by Mr. Bedford Russell.
Tues.,		19.—Dr. Gow and Mr. Girling Ball on duty. Last day for receiving matter for the July issue of the Journal.
Wed.,		20.—Surgery: Clinical Lecture by Mr. Roberts. Cricket Match v. Times C.C. Away.
Fri.,		22.—Medicine: Clinical Lecture by Lord Horder. Dr. Graham and Mr. Roberts on duty.
Sat.,		23.—Cricket Match v. Bournemouth. Away.
Tues.,		26.—Prof. Fraser and Prof. Gask on duty.
Wed.,		27.—Surgery: Clinical Lecture by Sir Charles Gordon-Watson.
Fri.,		29.—Lord Horder and Sir Charles Gordon-Watson on duty.
Sat.,		30.—Cricket Match v. Old Paulines. Away. Hospital Sports. Winchmore Hill.

EDITORIAL.

It has been characteristic of the medical profession to regard proposals of sudden or profound changes with caution and distrust. Innovations and metamorphoses have been met, therefore, by keen opposition, and their production is usually long delayed.

The medical curriculum and its discrepancies have been for so many years the subjects of sharp controversy that many have despaired of the long-hoped-for changes. With the Spring, however, there has blossomed the Report of the British Medical Association's Committee on Medical Education. It is to be expected that much fault with the proposals will be found by individuals, for opinions have differed widely, but the Committee are to be congratulated on dealing successfully with the main problems and difficulties that exist in the present curriculum. No really drastic changes are recommended. Perhaps the most important and far-reaching is the proposal that each student, before receiving full licence to practise independently, should have a period of about nine months under supervision, holding definite appointments in hospital or in general practice.

Many years must have passed since the Hospital was free from talk of rebuilding the wards. Though plans were passed three years ago for a new Medical Block, financial arrangements have only recently been completed.

The Governors of the Hospital have decided to proceed at once with the erection of a block of buildings to house the whole of the medical wards under one roof. This will represent the second stage of the great rebuilding scheme, which was started with the construction of the new Surgical Block and Operating Theatres opened in 1930.

The new Medical Block will occupy the site of existing buildings on the south side of the Quadrangle. These are approximately 180 years old, and are quite inadequate to meet the requirements of to-day. The block to be demolished consists of eight wards, each holding about 25 beds, and the new building will have 10 wards, each planned for about 23 beds. There will be five floors and a lower ground floor, and the building will be

constructed generally on the lines of the new Surgical Block, with which there will be direct communication on all floors. Construction will be in brick, but the original Portland stone facing of the existing building will be retained to maintain the architectural harmony of the Square. The new block will increase the number of medical beds by about 30, and bring the total beds available for patients at the Hospital up to 740.

The following very encouraging letter has been received:

"May 24th, 1934.

DEAR MR. EDITOR,

I wish you to give a very special prominence to the fact that every old Bart.'s man who is practising in the County of Worcestershire has subscribed to the College Appeal Fund. This is a magnificent accomplishment, and I am exceedingly anxious that every other county should emulate it.

"I wish to congratulate particularly Dr. Neligan, a very old friend of the Medical College, for the efforts by which he and his colleagues have achieved this result.

"The Lord Mayor of the City of London is permitting us to make an appeal at the Mansion House at a Banquet to be given on October 3rd, 1934. I am quite sure that the Public already appreciate what we have done for ourselves, and I am sure, too, that the effect of the Lord Mayor's assistance would be enhanced if we could say that every Bart.'s man has subscribed.

"Will you please give very prominent notice to the fact that Worcestershire has done this?

Yours sincerely,

"W. GIRLING BALL,
"Dean of the Medical College."

The list of contributions appears on p. 173.

We congratulate Mr. W. Girling Ball on being chosen to represent the General Medical Schools on the Senate of the University of London for the period 1934-1938.

Dr. L. P. Garrod has been appointed to the University Readership in Bacteriology.

Sir Thomas Dunhill has been elected a Member of the Central Council of the British Medical Association for the Session 1934-5.

Prof. Gask delivered the Annual Oration before the Medical Society of London on May 14th. His subject was "Clean Wounds, Ancient and Modern".

Mr. E. W. G. Masterman will give the Presidential Address on June 15th to the Metropolitan Counties Branch of the British Medical Association.

In the current issue of the *Bristol Medico-Chirurgical Journal* there appears the Presidential Address of Mr. H. Elwin Harris. It is entitled "Looking Back", and contains, *inter alia*, some interesting reminiscences of the Hospital in the 'eighties.

Mr. John Lionel Stretton, of Kidderminster, has recently completed his fiftieth year as a member of the Honorary Staff of the Kidderminster and District General Hospital. He has been president of the hospital staff for the last ten years, and has served as chairman of the County of Worcester Local Medical and Panel Committee for twenty years.

We congratulate Mr. J. P. Hosford on his rapid recovery from the effects of appendicectomy.

We also offer our congratulations to Mr. G. Weddell on being awarded the Commonwealth Fund Fellowship for the period 1935-37, to be occupied by research in America.

Miss Hilder has been appointed Second Assistant Matron, and Miss Pengilly has taken her place as Sister Children's.

We have been requested by Sir James Berry, Hon. Secretary of the St. Bartholomew's Hospital Seventh Decennial Contemporary Club, to state that the Annual Dinner will take place at the Trocadero Restaurant on Wednesday, July 4th, at 6.45 for 7.15 p.m. It is hoped that on this occasion there will be an unusually large attendance as, owing to the lamented death of Owen Lankester, the Club will have to elect a new Junior Hon. Secretary. We may add that this Club, the oldest of the existing Decennial Clubs of the Hospital, is still in a flourishing condition, and celebrated, last year, its fiftieth anniversary.

The Thirty-fourth Annual Dinner of the St. Bartholomew's Hospital Eighth Decennial Contemporary Club will be held at the Langham Hotel, Portland Place, W. 1, on Wednesday, June 27th, at 7.30 for 7.45 p.m. (price 10s. 6d.). Hon Secretaries: H. J. Waring and H. Morley Fletcher.

The following old Bart.'s men will hold office or speak at the One Hundred and Second Annual Meeting of the British Medical Association in July, 1934, at Bournemouth:

Medicine.—President: Prof. W. Langdon Brown, M.D., F.R.C.P. Discussion: Dr. Geoffrey Evans, Dr. J. Maxwell, Dr. A. W. Stott. *Surgery*.—Vice-President: Frank Belben, O.B.E., M.B., F.R.C.S. Discussion: Sir Thomas Dunhill, Mr. G. L. Keynes, etc. *Obstetrics and Gynecology*.—Paper: Mr. J. C. Ainsworth-Davis. *Neurology, Psychological Medicine and Mental Diseases*.—Discussion: opened by Lord Horder. *Pathology, Bacteriology and Biochemistry*.—Vice-President: Chas. G. H. Morse, M.R.C.S., L.R.C.P. Discussion: Dr. Geoffrey Bourne. *Radiology and Electrotherapeutics*.—Vice-President: W. Roy Ward, M.B., B.S. Discussion: Dr. A. J. Durdent-Smith, Dr. G. Harrison Orton, Dr. W. Roy Ward. *Anaesthetics*.—President: Charles F. Hadfield, M.B.E., M.D. (London). Discussion: Dr. Francis T. Evans. *Ophthalmology*.—Paper: Mr. T. W. Letchworth. *Orthopaedics*.—Vice-President: Eric I. Lloyd, M.B., F.R.C.S. *Oto-Rhino-Laryngology*.—Vice-President: T. H. Just, M.B., F.R.C.S. *Public Health*.—Vice-President: F. E. Chandler, M.D., F.R.C.P. Discussion: Dr. C. W. Hutt. *Dermatology*.—Hon. Sec.: Henry Corsi, M.B., F.R.C.S. *Medical Sociology*.—Vice-President: E. W. G. Masterman, M.D., F.R.C.S. *Hon. Science Secretary to the Meeting*: Dr. E. Burstal.

The Council of the British Medical Association has decided to offer for award in June, 1935, prizes for short clinical papers by fourth and subsequent year medical students and newly qualified practitioners of not more than one year's standing (that is, from date of passing qualifying examination), under the heading, "Describe two cases, from your own personal observations, illustrating the effects on the heart, immediate and remote, of acute rheumatic infection". Full particulars may be obtained from the *British Medical Journal Supplement*, May 12th, 1934, and from the College notice-boards.

We have been asked to announce that a week-end Post-Graduate Course will be held in June. The following lectures and demonstrations will be given:

Friday, June 22nd: Treatment of Asthma and Similar Allergic Diseases (Dr. G. Graham), Treatment of Sterility (Dr. W. Shaw and Mr. Kenneth Walker), Basal Anaesthesia (Mr. C. Langton Hewer), Skin Diseases—Diagnosis and Treatment with Cases (Dr. A. C. Roxburgh), Neurasthenia—Its Diagnosis and Treatment (Dr. C. M. Hinds Howell), Present State of Immuno-Therapy (Lord Horder), Saturday, June 23rd: New Opinions on the Causation and Treatment of Anemias (Dr. A. E. Gow), Demonstration of Therapeutic Diets (The Dietitian), Management of Patients with Minor Disorders of Ear and Throat (Mr. T. Just), Remedial Exercises with Demonstration (Mr. R. C. Elmslie and Sister Massage), Common Fractures of the Upper Limb (Mr. J. P. Hosford), Recognition and Treatment of the Causes of Chronic Pyuria (Mr. W. Girling Ball), Recent Drug Preparations and Indications for Their Use (Dr. E. K. Cullinan).

Fees.—Fee for the Course two guineas (or to St. Bartholomew's men one guinea), payable in advance.

Early application should be made to W. Girling Ball, Esq., F.R.C.S., Dean, to whom cheques should be drawn.

PERURETHRAL PROSTATIC RESECTION.

It is almost two years since Professor Cabot called the attention of the readers of this journal to the possibilities of perurethral prostatectomy. This operation is rapidly becoming of importance in prostatic surgery, and it may be of interest to record some of the first carried out in this Hospital.

The transurethral approach to the prostate gland is by no means an innovation. As long ago as the middle of the last century Mercier made attempts to divide the bladder neck with a urethrotome, and later, Bottini used a galvano-cautery punch to make a tunnel through the prostate. Numerous modifications and improvements were made on these instruments by various workers, but the method gradually fell into disrepute for three main reasons: (1) being a blind operation no control could be kept on the amount of prostatic tissue removed or damage done to surrounding tissues; (2) considerable sepsis often followed, this being largely due to the septic material left behind in the bladder; and (3) severe hæmorrhage frequently occurred. It is obvious that the ideal instrument must be one which not only gives a good view of the site of operation, but at the same time permits the removal of the excised prostatic fragments from the bladder and secures hæmostasis.

An instrument which combines these principles is the improved McCarthy's prostatic electrotome. This consists of an outer sheath, an articulated obturator, a carrier with a foroblique telescope, an irrigating system, and a cutting wire loop controlled by a rack and pinion. The wire loop is activated by a cutting current, which gives satisfactory hæmostasis. The foroblique telescope and the continuous irrigating apparatus give a good view and a clear field at the site of operation.

A general or spinal anaesthetic is necessary, and the pre-operative treatment is the same as for the supra-pubic operation. The renal function must be estimated, and if there is urinary infection or a large amount of residual urine a catheter must be tied in and the bladder drained.

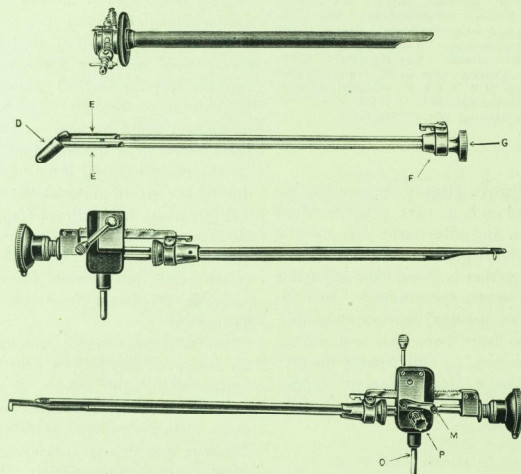
The operation is conducted with the patient in the lithotomy position. The sheath and obturator are introduced *per urethram*, the obturator withdrawn and the carrier inserted. The carrier includes the wire loop, the telescope and the continuous irrigating apparatus. The wire loop is put into the cavity of the bladder beyond the obstructing prostatic tissue, the current turned on and the lever controlling the loop is turned slowly, bringing the loop backwards for about an inch and thus cutting through the obstruction. The carrier

is then withdrawn from the sheath and the fragment of prostatic tissue removed by forceps from the wire loop. It is again introduced, and several cuts are necessary to obtain a clear channel. If the controlling lever is drawn over slowly the cutting current produces satisfactory hæmostasis. The chief source of sepsis is dealt with, since each fragment of prostatic tissue is removed when the carrier is withdrawn. At the end of the operation the bladder is washed out and a soft rubber catheter tied in.

The perurethral operation is not, however, to be regarded as a general substitute for suprapubic prostatectomy. In the main there are three indications for the perurethral route:

(1) In cases where the general enlargement of the prostate is small but the obstruction is great. This meets the requirements of the well-recognized case where there is considerable obstruction and intravesical projection, but little enlargement of the prostate as felt *per rectum*.

THE MCCARTHY ELECTROTOME.



THE SHEATH, THE ARTICULATED OBTURATOR, THE LOOP ELECTRODE CARRIER WITH FOROBLIQUE TELESCOPE (TWO VIEWS).

(By kind permission of the G.-U. Mfg. Co.)

The after-treatment is mainly directed against the occurrence of sepsis: the bladder is washed out daily and the patient encouraged to drink freely. There is little or no pain, and the hæmorrhage is usually negligible. The catheter is removed on the third day and the patient is usually fit enough to go out on the fifth. There may be loss of control of micturition for some time following the operation till the muscle of the bladder neck regains its tone.

The advantages over the suprapubic operation are obvious. The risks of the latter, even in experienced hands, are considerable, not only from shock and hæmorrhage, but from a prolonged stay in bed at an age when a man is particularly unfitted for it.

(2) In special circumstances where total removal is contra-indicated owing to the poor general condition of the patient, poor renal function or cardiac or pulmonary complications.

(3) In certain cases of scirrhous carcinoma of the prostate.

The following are cases which have recently been in the hospital and demonstrate the above indications:

CASE 1.—Wm. C., æt. 71, a jobbing builder, was admitted to Abernethy Ward on March 14th, 1934, complaining of "difficulty in passing water".

For the previous three years he had increasing difficulty in micturition, a dribbling stream, and a night frequency of 2. He had no hæmaturia or retention, and was otherwise well.

On examination he proved to be a comparatively fit man apart from some emphysema of the lungs. *Per rectum* the prostate was

not enlarged. Urine clear, no albumen, no red cells, no pus-cells seen, sterile on culture. Residual urine 7 oz.

	Urea (%).	Urine (c.c.).
Urea concentration test—1st hour	2.30	64
2nd "	3.05	49
3rd "	3.30	50

March 16th: Cystoscopy by Mr. Ball showed considerable intravesical projection of the prostate and some degree of sacculcation of the bladder.

March 20th: Perurethral prostatic resection by Mr. Ball; general anaesthesia. McCarthy's urethrotome was used, and about eight fragments of prostatic tissue removed, till a gutter was made and a large soft rubber catheter tied in.

March 23rd: Catheter removed; patient started passing water easily, but with poor control for 24 hours.

March 25th: Residual urine 2 oz., control good; stream much improved; patient passing water freely.

Section showed innocent adenomatous enlargement of the prostate.

This case shows the main indication for the perurethral route, *i. e.* considerable obstruction to the urinary flow but no gross enlargement of the prostate.

CASE 2.—W. D., æt. 64, motor coach proprietor, admitted to Abernethy Ward March 8th, 1934, complaining of "inability to pass urine".

For the previous six years patient had difficulty in passing urine, a dribbling stream and a micturition frequency of D. 12, N. 3.

Three days before admission patient had complete retention of urine which was relieved by catheterization.

He had a five years' history of chronic cough, and shortness of breath for the last three years.

On examination he had cirrhotic facies, a frequent loose cough, and was dyspnoic after the effort of undressing. He had signs of chronic bronchitis and emphysema, blood-pressure 164/90 and a palpable liver. *Per rectum* the prostate was moderately enlarged, soft, smooth and mobile.

A catheter specimen of urine contained about 5 red blood-cells per $\frac{1}{4}$ field, and was sterile on culture.

	Urea (%).	Urine (c.c.).
Urea concentration test—1st hour	1.25	18
2nd "	1.45	49
3rd "	1.60	114

A catheter was tied in and the bladder decompressed.

March 13th: Cystoscopy by Mr. Ball showed considerable intravesical projection of the prostate.

March 20th: Perurethral prostatic resection by Mr. Ball; spinal anaesthesia by Mr. Langton Hewer. McCarthy's urethrotome was passed and several large pieces of prostatic tissue removed. There was considerable primary hæmorrhage, but this was satisfactorily controlled by irrigation with water at 108° F. A soft rubber catheter was tied in.

March 23rd: Catheter removed; patient incontinent.

March 25th: Patient passing water well; stream good; control satisfactory. Residual urine 2 oz.

Section showed innocent enlargement of the prostate.

This case is of interest in that it demonstrates the value of the operation when the patient's condition contra-indicates the suprapubic operation. The degree of pulmonary and cardiac complications in this case was such that it would have been unsafe to attempt any more radical operation.

CASE 3.—A. L., æt. 71, a fireman, admitted January 9th, 1934, complaining of difficulty in passing water and pain in the pelvis.

One year previously he started to experience a bearing-down pain in the pelvis on any attempt at micturition; the stream became progressively weaker—frequency, D. 14, N. 5.

One month before admission he had acute retention of urine, which was relieved by catheterization; after this he had considerable

difficulty in starting micturition and could only pass 2 oz. of urine at a time.

He was somewhat short of breath and suffered from palpitations. On examination a large, well-covered man, with emphysematous lungs. Blood-pressure 158/80. *Per rectum* the prostate was hard and fixed, but not enlarged. Urine clear, no albumen, no red blood-cells seen, and sterile on culture.

	Urea (%).	Urine (c.c.).
Urea concentration test—1st hour	3.35	66
2nd "	3.50	83
3rd "	3.00	25

A catheter was tied in and the bladder decompressed.

January 16th: Cystoscopy by Mr. Ball showed small intravesical projection of the prostate; the bladder was otherwise healthy.

A diagnosis of carcinoma of the prostate was made and a course of deep X-ray therapy given. Ten days after this was completed the catheter was removed, but the patient was unable to pass urine.

February 15th: Perurethral prostatic resection by Mr. Ball. Several large fragments of the prostate were removed with McCarthy's electrotome, and a gutter made; a catheter was tied in.

February 20th: On alternate days after this the catheter was removed for four hours at a time, but the patient was still unable to pass urine.

March 5th: Mr. Ball carried out further prostatic resection with McCarthy's instrument. The trouble appeared to be due to the projection of the lateral lobes. About twelve large fragments were removed and a catheter again tied in.

March 10th: Catheter removed; patient passing water with difficulty.

March 14th: On discharge, passing urine fairly freely; stream poor; frequency D. 12, N. 4; urine clear, patient well.

Section of fragments removed showed carcinoma of the prostate.

The value of the operation in this case was two-fold: it confirmed the diagnosis, and gave relief, though possibly only of a temporary nature, to a man who was otherwise condemned to a permanent suprapubic apparatus.

One other case is of interest because of an associated diverticulum of the bladder:

CASE 4.—W. W., æt. 50, a machinist, admitted to Abernethy Ward on September 11th, 1933, complaining of difficulty and pain on passing water.

Ten years previously he experienced difficulty in micturition, which had increased in severity in the last few years; he also complained of a burning pain at the tip of his penis at the end of micturition. His urine was usually clear, but sometimes became very thick; stream poor; he was otherwise well.

On examination he was thin and looked ill; he had signs of a healed tuberculous focus at the apex of the left lung, and the bladder was distended up to the level of the umbilicus. *Per rectum* the prostate showed slight general enlargement; the median groove was discernible and the consistency was firm.

Urine turbid, numerous pus-cells in a standing deposit and *Staphylococcus aureus* grew on culture. Blood urea, 40 mgrm. %.

	Urea (%).	Urine (c.c.).
Urea concentration test—1st hour	1.65	32
2nd "	1.85	44
3rd "	1.70	40

September 15th: Cystoscopy by Mr. Ball. Urine withdrawn was foul. The bladder washed clean easily, but it rapidly became turbid again. Owing to this factor, accurate cystoscopic observation was not possible, but appearances suggested a sacculus.

A catheter was tied in and the bladder drained.

September 22nd: Cystoscopy by Mr. Underwood. A flushing cystoscope was used, and the opening of a diverticulum was seen above and just outside the right ureteric orifice. On respiration debris and pus were seen pouring from the diverticulum. A cystogram was taken.

October 3rd: Excision of diverticulum of bladder by Mr. Ball; general anaesthesia. The bladder was distended and opened through a suprapubic midline incision. A sac 3 in. in diameter was found

lying behind and to the right of the bladder. The wall of the sac was thick and muscular, and it was adherent to the right ureter and the vas. It was dissected free and excised. The bladder was drained suprapubically and the wound closed in layers. It was noticed at the time of operation that there was a mild degree of intravesical prostatic enlargement.

The wound commenced to heal satisfactorily, and the suprapubic catheter was removed on the twelfth day. A 10/13 urethral sound was passed on the twentieth day, but the patient failed to pass any urine naturally. A catheter was therefore tied in and the suprapubic wound healed, but repeatedly broke down when the catheter was removed.

January 9th, 1934: Perurethral prostatic resection by Mr. Ball. The McCarthy's urethrotomy was passed and a moderate degree of intravesical projection of the prostate was present. Several fragments of the prostate were then resected until a satisfactory gutter was obtained, and a rubber catheter was tied in.

January 12th: Catheter removed; patient started passing urine immediately.

January 18th: Wound soundly healed; patient well; passing urine easily; stream good, urine clean.

Section showed senile hypertrophy of the prostate.

I am indebted to Mr. Girling Ball for permission to publish these cases, and for many helpful suggestions in the preparation of this article.

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 W. M. CAPPER.

HIS MAJESTY IN VITRO: A FAIRY-TALE FOR PATHOLOGISTS.

KING IVAN of Improbolia ascended the throne at the early age of two. "Ascended" is the right word, for our obstinate princeling insisted upon mounting unaided that formidable piece of furniture. The court chamberlain, neglectful of the warnings of history, had forgotten to invite to the coronation ceremonies the local Bad Fairy. So she, quite naturally, gate-crashed, turning the hall porter, who attempted to detain her, into an anencephalic fetus.

Bursting into the midst of the rejoicings she proceeded to prophesy disasters. "Bloodshed, pestilence and famine," she began cheerfully, "shall wipe out Improbolia . . ." But then the Good Fairy stepped forth. Foreseeing that trouble might follow from the chamberlain's lack of tact she had laid in an assorted lot of anti-charms and counter-curses. "This prophecy," she said, "shall never come to pass until the Royal House of Improbolia is extinct." She was a well-meaning fairy but not bright; the move was an obviously weak one, as fans who have followed the game will realize. Quick

as lightning came the Bad Fairy's reply: "King Ivan," she lisped—and those are hard words to hiss effectively—"shall die of *status lymphaticus* on his third birthday." But the Royal Pathologist, who was acting as referee, ruled this curse out of order, as the Improbolian Society of Pathologists had lately decided that *status lymphaticus* did not exist. The Bad Fairy was allowed another turn: "Ivan shall die on his third birthday of idiopathic cachexia." Now this curse is quite valid in Fairy Law, so the Royal Pathologist had to let it pass. Now the Good Fairy was well-meaning, as I said before, but not bright, and she had no idea what idiopathic cachexia might mean; and she had no counter-charm of any use at all, so she looked helplessly appealing and feminine and declared, "The people shall appoint the Royal Pathologist absolute dictator for one year" (which perhaps shows that she was smarter than we thought). Anyway that concluded the proceedings, as they were playing under Queensberry rules and only had two shots each. The Bad Fairy withdrew, glowering and snarling.

A year had passed. Everyone was acutely nervous except the Royal Pathologist. At breakfast-time King Ivan appeared quite well, but at ten o'clock he began to fade away and by noon he was dead. Nothing could conceivably have been more idiopathic. The Royal Pathologist at once held a post-mortem; and an hour or two later he came forth holding in his hand a little glass vessel. "Le roi est mort," he said, in his guttural Improbolian voice, "Vive le roi." The people were mystified; the Bad Fairy was jubilant. "People," continued the Royal Pathologist, "the House of Improbolia is *not* extinct; the curse is not yet fulfilled. Modern science has found out how to grow living tissues in culture-media and to keep them growing year after year. I have in this little flask a fragment of King Ivan's heart in tissue-culture; it is still beating! Long may it beat! In other flasks are pieces of various other tissues." Loudly the people cheered; the Bad Fairy withdrew, glowering and snarling.

Of course she contested the Royal Pathologist's claim in the Supernatural Division of the Improbolian Law Courts, but it was ruled that the Royal House of Improbolia was not extinct as long as any of its cells were alive. Before long the people became accustomed to *in vitro* Royalty. His Majesty's incubator was placed on the throne when levees were held. The Eunuchs of the Royal Household were bled in turns to furnish plasma for renewing H.M. culture medium. This renewal was conducted with much pomp by the Royal Pathologist, attended by the Royal Chef and the Keeper of the King's Bath. The Chef contended that the

ceremony essentially involved supplying His Majesty with fresh nourishment; the Keeper of the King's Bath thought it definitely came into his department. For a time the Royal Pathologist pinned his hopes on a culture of H.M. germinal epithelium and had visions of securing a succession to the throne. But, alas, that culture died out in a week or two. Moving pictures were, however, taken of H.M. heart and H.M. ciliated epithelium, and their showing always evoked loud applause at the cinema theatres.

* * *

But the Bad Fairy was not idle. She was foiled in an attempt to interfere with the regulator taps of H.M. incubator. So she and a number of attendant sprites turned themselves into *Bacillus subtilis* spores, leapt into the Tyrode's solution used for H.M. culture media, and so found entry into H.M. flasks themselves. In a few days King Ivan was dead (finally, this time, gentle reader), hopelessly contaminated. The run which fell upon Improbolia thereafter was complete. So completely have its records passed into oblivion that you have probably never heard of the country; which, of course, proves that my story is true. C. H. A.

MUCOCELE OF THE FRONTAL SINUS WITH DISPLACEMENT OF THE EYE.

THE patient, a manservant, *æt.* 35, was admitted on January 19th, 1934, his chief symptoms being downward displacement of the right eye and diplopia. Eleven months before admission he began to suffer from supraorbital headaches, coming on most frequently in the evening, and about the same time he began to have double vision. This association of symptoms suggested a defect of the eye itself, and spectacles were accordingly prescribed for "squint." The condition continued unchanged, however, until four months before admission, when the patient first noticed that his right eyeball was being displaced downwards and becoming prominent. It was at this time also that he first became aware of a tender swelling of firm consistency at the upper and inner part of the right orbit. A tentative diagnosis of new-growth of the orbit was made, and as such the case was sent up to this hospital for immediate admission. There had been no watering of the eye, and there was no history of chronic discharge from the nose, nor of injury to the eye or frontal region.

On admission the left eye appeared normal. The right eye showed marked ptosis of the upper lid, and the eyeball was protruded and displaced downwards

(Fig. 1). There was some limitation of movement upwards and medially. At the upper part of the inner angle of the orbit was an oval swelling, measuring 1 in. by $\frac{1}{2}$ in., extending from under cover of the supra-orbital margin on to the medial third of the upper lid. The surface was smooth and the margins regular and well defined except above and behind, where the extent of the swelling could not be determined. It was tense and



FIG. 1.—BEFORE AND AFTER OPERATION.

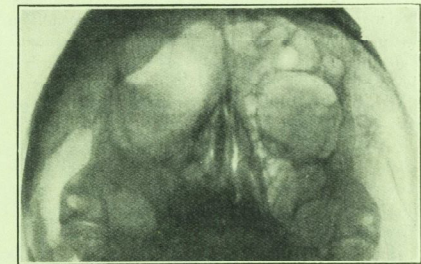


FIG. 2.—RADIOGRAM OF SKULL (OCCIPITO-MENTAL VIEW).

fluctuant and the skin over it normal and freely movable. There was a little tenderness to pressure at the outer part of the swelling. The fundus of the eye was normal, but vision was impaired. No signs of disease were to be found in the nose. X-rays (Fig. 2) showed that the frontal sinuses were very large, especially the right one, and the right superior orbital margin was eroded at its inner end. The right maxillary antrum was opaque. The swelling was aspirated and a creamy yellow fluid drawn off, which was found to be sterile.

The diagnosis of mucocele of the frontal sinus was

made, and Harmer's operation for drainage of the sinus was performed by Mr. Capps. Puncture of the maxillary antrum was first attempted, but no pus was discovered. An incision was made along the inner end of the eyebrow, and the periosteum elevated. The frontal sinus was found to be greatly distended, its cavity extending into the orbit. A part of the floor of the sinus was absorbed, so that its cavity could be entered without passing through bone. Free intra-nasal drainage was established, and a soft rubber catheter inserted into the sinus from the nasal cavity, and left *in situ*. The external wound was closed, and the catheter secured by means of a thread strapped to the forehead. When seen seven weeks after the operation, the external wound was well healed. Some muco-pus was draining away by the catheter. The headache was completely gone, the eye showed a less degree of displacement, and vision, though not equal to that in the left eye, was considerably improved.

The interest of this case lies in the diagnosis and the comparative rarity of the condition. In the early stages diplopia and supra-orbital headache, with no noticeable swelling or displacement, were unusual, and suggested involvement of the eye itself. Later the proptosis and displacement of the eyeball were very suggestive of a new-growth situated in, or encroaching on the orbit. The finding of a fluctuant swelling above the inner canthus was the clue to the actual condition, confirmed by the presence of sterile fluid contents. The difficulty in the diagnosis of frontal mucocele is chiefly due to the fact that the symptoms may be entirely referable to the orbit, evidences of nasal disease often being absent (1). Out of the 7 cases recorded by Logan Turner in 1907 (2), there was displacement of the eye in 6, and in none was there any nasal discharge. Howarth (3) records 15 cases of mucocele of the frontal sinus and anterior ethmoidal cells, and in all but 2 of these the nasal examination was negative.

The most important differential diagnosis has to be made from *new-growths* of the frontal sinus and orbit. If the bony walls of the sinus are distended, the swelling is hard and osteoma may be suspected. As the bone becomes rarefied the swelling comes to feel softer, and must be distinguished from sarcoma or fibro-sarcoma. An osteoma encroaching from above into the orbit will produce displacement of the eye and diplopia as in mucocele. Howarth (4) describes a case which had the appearances of a mucocele, and its true nature was discovered only on making a microscopic section, when it was found to be a fibrous osteoma. An X-ray is often very helpful in deciding between neoplasm and mucocele.

When the early symptoms are a swelling at the medial side of the orbit with epiphora, *cystic dilatation of the*

lacrymal sac may be suspected. Howarth mentions that in his series this condition had been diagnosed in three cases, in one of which the sac had actually been removed. The position of the swelling may be a guide in the differential diagnosis; in frontal mucocele it is usually situated above and lateral to the sac, but if anterior ethmoidal cells are involved, it is lower, and the distinction may be difficult. Firm pressure on a lacrymal sac, however, will usually express some of the retained contents into the nose or inner canthus.

Finally *dermoid cysts*, though far commoner at the outer angle of the orbit, do sometimes occur at the inner angle.

Pathology.—The disease has for some time been recognized as a separate clinical entity, distinct from the usual chronic inflammatory diseases of the para-nasal sinuses. It consists of the accumulation of mucus within the sinus, with thinning and sometimes distension of one or more of its walls. Various views as to the aetiology have been put forward. Some authors assume a cystic degeneration of the lining mucosa, or of polypi (5), or a cystic dilatation of the mucosal glands. The most general view, however, seems to be that the condition is due to a pre-existing catarrh, with cicatricial contraction and stenosis of the fronto-nasal duct. Howarth considered that injury was the exciting cause in five of his cases.

I should like to thank Prof. Gask for permission to publish this case, and Mr. J. P. Hosford and Mr. Capps for much help in preparing these notes.

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K. O. BLACK.

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COLLEGE APPEAL FUND.

SUBSCRIPTIONS TO DATE.

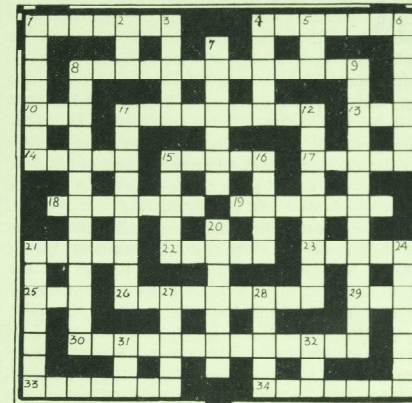
Staff	£	s.	d.	*
Demonstrators	12,666	9	10	(27)
Students	1,674	11	0	(67)
Old Bart.'s men:	752	0	5	(285)
Bedfordshire	12	11	6	(4) . (26)
Berkshire	96	1	0	(14) . (37)
Buckinghamshire	74	19	0	(13) . (29)
Cambridgeshire	165	14	0	(13) . (42)
Cheshire	1	1	0	(1) . (26)
Cornwall	22	2	0	(5) . (36)
Cumberland	5	0	0	(1) . (6)
Derbyshire	19	14	0	(4) . (17)
Devonshire	557	14	0	(52) . (117)
Dorset	52	1	0	(14) . (30)
Durham	16	6	0	(3) . (11)
Essex	229	19	6	(17) . (69)
Gloucestershire	212	13	6	(20) . (66)
Hampshire	406	14	0	(38) . (134)
Herefordshire	13	3	0	(4) . (11)
Hertfordshire	76	3	0	(13) . (73)
Huntingdonshire	18	13	0	(12) . (4)
Isle of Wight	558	3	0	(64) . (146)
Kent	91	4	6	(12) . (82)
Lancashire	133	12	0	(6) . (28)
Leicestershire	52	11	0	(13) . (25)
Lincolnshire	382	3	0	(18) . (68)
Middlesex	150	7	6	(18) . (60)
Norfolk	54	4	0	(4) . (17)
Northamptonshire	101	1	0	(2) . (11)
Northumberland	13	13	0	(2) . (28)
Nottinghamshire	185	3	0	(18) . (29)
Oxfordshire	35	9	0	(8) . (22)
Rutland	1013	10	0	(26) . (43)
Shropshire	194	18	0	(6) . (37)
Somersetshire	274	1	0	(18) . (46)
Staffordshire	434	16	6	(47) . (180)
Suffolk	275	2	0	(49) . (170)
Surrey	178	1	6	(18) . (56)
Sussex	1	0	0	(1) . (5)
Warwickshire	97	11	0	(11) . (26)
Westmorland	133	19	6	(24) . (24)
Wiltshire	270	4	6	(21) . (104)
Worcestershire	56	4	0	(12) . (150)
Yorkshire	2,759	16	8	(177) . (971)
Wales	10	0	0	(1) . (9)
London	14	4	0	(4)
Channel Islands	48	5	0	(7)
Scotland	326	10	6	(27)
Abroad	113	2	6	(8)
South Africa	72	7	0	(8)
Canada	146	10	0	(5)
East Africa	152	0	0	(7)
West Africa	4	0	0	(1)
India	2	2	0	(1)
Ceylon	5	0	0	(1)
Syria	14	14	0	(3)
U.S.A.	1	0	0	(1)
Ireland	1	0	0	(1)
North Africa	5	5	0	(4)
North Borneo	12	2	0	(3)
Australia	1	1	0	(1)
Friendly Islands	4	2	0	(2)
Egypt	6	0	0	(2)
Malay States	46	8	4	(8)
China	10	0	0	(1)
Siam	50	0	0	(1)
France	22	2	0	(2)
Trinidad	23	1	0	(3)
British West Indies	2	1	0	(2)
New Zealand	54	14	0	(34)
Services	31,844	13	4	(293)
Others				

£58,167 11 1

* Number of Bart.'s men subscribing.
† Number of Bart.'s men in County.

CROSSWORD PUZZLE.

Solutions may be sent to the Editor. A de luxe copy of Round the Fountain will be given to the sender of the first correct solution opened after June 14th. Envelopes should be marked "Crossword".



ACROSS.

1. 1/2 of 2.
4. Osseous incitement to vulgar theft by the fruit of a dog-rose.
5. Coy Miss in a cot (anag.).
10. Cockney innuendo of little interest.
11. Such a game is dramatic.
13. A short chapter turns this Pharm. abb. into a child's wrap.
14. Sylvan Gastrologist.
15. Accelerating projections.
17. Flat roof from the dealer's left, used in electrocardiography.
18. Even the short account of this acid is redundant.
19. Fifty on an island; used by mothers?
21. A small expert department.
22. Poetic perch?
23. This sphygmeter, maybe, is odd.
25. Eerie!
26. A singing horse is devilish metallic in our company.
29. Grouse without employment in Old Rome.
30. I measure a wee drappie.
33. Damaged caddy? Stilton is.
34. Gangrenous Castilian warrior—must have "got it in the neck".

DOWN.

1. With three exclamations I go bhong!
2. Good German pull up exposing bowel.
3. The only belief compatible with its opposite.
4. Hundredfold.
5. What's the matter?
6. Clot that gives 'em a lump in the throat.
7. Policeman who, when French, is a mere quantity of motion.
8. Such communication creates a bit of a hum.
9. Pals cry around (anag.).
11. Nervous disorder follows the discovery of crushed headgear in an automobile (Movie caption!).
12. Lunar acid.
13. Quill in the flesh of many of Caesar's contemporaries.
16. Notarial calculus.
20. Body cavity.
21. This type of abscess, opened, looks rather fishy.
24. Sweet station in the South of France.
27. Premonitory symptom of corns in the ear.
28. Acid, orderly when a conservative.
31. I paralyse the external sphincter.
32. Associated with plumage in an act of violence.

LOPEZ THE JEW.



TH such a name he might have been a Barbary pirate; or one of those furtive and fabulously wealthy Jews of the Middle Ages. Or he might have been a pugilist like the great Mendoza. Quite a number of fantastic and picturesque careers are suggested, and each could easily be attributed to such a name. But he was, in sober fact, a physician to St. Bartholomew's; and although one would like to add, as a natural sequence, that he was eminent for his great learning, wisdom and piety, the further fact is that he most certainly died on a Tyburn gallows.

His story, for those who care to read it, is a strange one. His first name was Roderigo; his surname Lopez, written also variously as Lopes and Lopus. To the Elizabethan populace of London he was eventually notorious as Lopez the Jew. He was born, in about 1530, of a Jewish family long resident in Portugal, amongst whom the profession of medicine seems to have been followed for many generations. He pursued his studies in some warm Mediterranean university, unknown to us; he practised in Italy, married a Jewish wife from Antwerp and came to England in 1560. At the same date he was most happily converted to the Christian faith; and this was especially fortunate, since Jews were not permitted at the time to settle in this country. In 1561 he joined the Royal College of Physicians, and began gradually to acquire a fashionable and influential practice. In 1569 he should have lectured for the College on Anatomy, but having other preoccupations, was in default of this duty fined £4.

In the meantime he had been appointed Resident Physician to St. Bartholomew's. As such he was the first to hold office. In return for his services he had a house and garden within the Hospital precincts, and was paid the sum of forty shillings a year. In this house he lived with his wife and family—a considerate husband, as his letters show, and the father of numerous daughters. From this house, too, he proceeded gravely twice a week to attend to his patients in the Hospital's wards. We may picture him, I suppose, as a sedate and presentable man with his many cares hidden behind a smooth countenance, bearded, and with his spare form clad in a rich yet sober gown. Of the manner in which he performed his duties we have varying accounts. One of the surgeons with whom he worked observes that he was "careful and very skilfull . . . in dyeting, purging and bleeding"; and Bacon, who wrote an account of his subsequent treason, describes him at this time as "observant and officious, and of a pleasing and applicable behaviour". The Governors

of the Hospital, on the other hand, in 1575, ordered his parlour to be boarded, but only on condition that he were "more painfull in lookynge to the poore of the hospitall". Shortly afterwards he applied for permission to move further into the City, and in 1580 he relinquished his appointment.

He had, as a matter of fact, private concerns which occupied more of his time than he could well spare to the Hospital, and which he hoped would better repay him. Soon after his arrival in England he had attended the Earl of Leicester, and in 1586, through his influence, he became Physician to the Queen. Our Dr. Lopez, with his soft and confidential tread, was now to be seen in the royal antechambers; but however warily he walked henceforth, his responsibilities and intrigues were to make his last years uneasy. His fate was curiously linked with that of a certain Don Antonio, who came, like himself, from Portugal. Don Antonio was an adventurer, and at the moment a refugee, claiming to be the rightful king of Portugal; and in spite of his transparent pretence, he was well received in England for political reasons. Dr. Lopez was appointed to interpret between him and Queen Elizabeth, and came in time to manage much of his business. At this point the story becomes somewhat involved, owing to the partisan nature of contemporary accounts, but this much seems clear. Amongst Don Antonio's friends was the great Earl of Essex, and he also on occasions employed our Dr. Lopez when such a man could be of use to him. Poor, busy, scheming Dr. Lopez; he chanced unluckily to betray some secret of the Earl's, and was denounced to Don Antonio. He fell forthwith from Antonio's favour, and later from the Queen's.

At this juncture, a critical one, there appeared on the scene some enemies of Don Antonio's from Spain, who approached Dr. Lopez with this sinister project—that "Don Antonio should die, the first illness that befell him". Dr. Lopez agreed, and received from Spain "a very goodly jewel". But this was not all. If Don Antonio, a poor pretender, had his enemies, much more had Elizabeth of England. Dr. Lopez was approached again, this time with the proposal that a similar illness should befall the Queen. He hesitated; and while he was considering the plan, the Earl of Essex caught wind of it and exposed the whole plot. Dr. Lopez was arrested for treason, and soon the news was abroad throughout London "that old Doctor Lopus is in the Tower for intelligence with the King of Spain". This was the antique little London of timber houses that lay neatly within its walls between green fields and the sparkling river; the tidings flew apace along its narrow streets.

The trial took place in the Guildhall and was

protracted to a great length. Popular feeling ran high. The "goodly jewel" was found amongst his papers, and was taken as damning proof of his guilt, explain it as Dr. Lopez might, and protest he his innocence never so loudly. He was threatened with the rack and made confession, being by now an old man, and was at length pronounced guilty and "worse than Judas himself". An immense crowd assembled at Tyburn to watch his execution, and deafened him with their jeers when he tried to speak from the scaffold. So perished, in 1594, Dr. Roderigo Lopez, late Physician to St. Bartholomew's Hospital.

What shall we say, then, in conclusion? Peace to his memory? But no one remembers him; even I—who spent an afternoon pursuing his dim and misty figure through old pages in the Guildhall Library—even I will forget him very soon. So let's say farewell. Farewell, old Lopez!

M. H. C.

A LETTER FROM VIENNA.



HEN M. P. M. and I decided to go abroad for a three months' study of anatomy we chose Austria rather than Germany, believing at that time that Germany was in too great a state of unrest for peaceful study. Little did we know then that we were entering a city seething with unrest, and ready to break out into revolution at any moment.

After an uneventful journey of some thirty-six hours we arrived in Vienna, and next morning set out to explore the city and to present our credentials to the Professor of Anatomy. When we called Prof. Pernkopf was conducting examinations, so we took this opportunity of inspecting the Institute in which we proposed to spend the next three months.

It is a very fine building situated close to the University, and extremely well equipped. There are about five hundred students. Each dissecting table is as well lighted as most operating tables; the material is well preserved and adequate, each student alone having to dissect half the body in the course of his studies. The first term is devoted entirely to the study of bones and the dissection of joints. A very useful innovation is the "studier local", where students may obtain from the attendant any specimen they may wish to study. At the end of term each student has a "viva" lasting from twenty minutes to two hours, according to the mood of the Professor. These take place in the lecture theatre, and anyone wishing to attend may do so.

We were very graciously received by Prof. Pernkopf, who, as soon as he understood our needs, summoned

one of his prosectors—Dr. Pichler—and put us in his care. For the rest of our stay we dissected in Dr. Pichler's private dissecting-room, which was even more efficiently equipped than the main dissecting rooms. Here it was that we had coaching in a mixture of German and Latin, and here also we spent a very interesting morning with the recently retired Prof. Hochstetter, whose researches into embryology are too well known to require further mention.

Each morning saw us at a lecture which we had little difficulty in understanding, the only disturbing element being the police, who would sometimes turn out as many as twenty strong to arrest some unfortunate student who had been heard singing a Nazi song or otherwise misbehaving himself. These fellows would disappear to a concentration camp, and not be heard of for six months, when they would return looking thin and full of nothing but politics.

The week-ends were mostly spent in a hut on the Schneeberg or Rax Alp, about fifty kilometres from Vienna, approached by train and mountain railway. Here we learnt to ski, but these are no mountains for a beginner, as the slopes are precipitous and mostly covered in ice at this time of the year. Of the two, the Rax Alp is the worse, having an almost perpendicular route down its side which zig-zags through the woods; falling only accelerates one's downward career. There was, however, plenty of amusement to be had from them, and they made a good training-ground preparatory to five excellent days at Radstadt on the way home.

It was on our return from one of these week-end expeditions that we arrived, weary and sore, to find Vienna in a state of darkness and warfare. We chartered one of the few available taxis, but were constantly held up by militia and barbed wire entanglements, eventually having to take a soldier on board before getting back to the pension. It was fortunate that we happened to have our passports with us.

For the next fortnight we knew very little of what was happening, as all the papers were strictly censored. The nights were made hideous by the roar of heavy artillery pounding away in the suburb of Floridsdorf. There the Socialists were desperately defending one block of flats after another, escaping from one doomed house to the next by way of the sewers in an attempt to reach the Czecho-Slovakian border. Some of these men were subsequently a source of menace to the populace, as they would appear from a sewer and shoot at anybody who happened to be passing. Barbed wire everywhere and a constant showing of passports made progress difficult. During this trouble, as the University was shut, we obtained special passes and dissected alone and in comparative peace.

After these episodes the fracture clinic of Prof. Böhrer proved an interesting museum of gunshot wounds and lacerations. Gas gangrene was prevalent, there being twenty to thirty deaths from this cause in Vienna alone. Prof. Böhrer had no deaths whatever, and this is all the more interesting as he used no serum, though he found the organism in the pus of many wounds. He put his faith entirely in the well-tried methods of excision and complete rest of the injured part.

We found the Austrians, individually, to be an extremely hospitable and friendly people with a well-developed sense of humour. It was with the greatest regret that we had to take our departure from them.

R. H. H. W.

ABERNETHIAN SOCIETY.

The election of officers for the ensuing year resulted as follows:

Presidents: A. Innes, A. H. Hunt.

Vice-Presidents: J. A. Squire, P. H. Ghey.

Hon. Secretaries: G. Blackburn, H. Noel Davis.

Extra Committeemen: D. B. Fraser, G. A. Fairlie-Clarke.

A vote of thanks was passed to the retiring officers, and the hope expressed that A. H. Hunt would soon be able to resume his duties.

STUDENTS' UNION.

ATHLETIC CLUB.

The opening match took place on May 3rd against Emmanuel College, at Fenner's. Although the sides were not fully representative the issue was close, and Emmanuel only gained their 6 points victory in the last event. Individually, and in spite of an obvious lack of training, the performances were very satisfactory, Jopling, Perrott, Collart and Dransfield winning their respective events. The sprinting of E. L. Davis, the Cambridge A. C. President, and the weight-putting of A. W. Carver proved too strong for our men, though in the latter event D. B. Fraser's effort of 37 ft. 7 in. showed that he should be an asset to our team strength.

The University of London Sports were held on May 3rd and 5th. The Athletic Club Committee had decided not to enter a team; our only representation was individual in three events. However, since K. W. Martin won the pole vault, C. P. C. Reilly the 440 yards hurdles—this in the record time of 57½ sec.—and Dransfield was second in the javelin, the outcome was reassuring.

An athletic match took place between St. Bartholomew's Hospital A.C. and Southgate Harriers on the evening of May 16th, which was won by the Hospital by 57 points to 41.

A cold wind and rather heavy going combined to prevent any record-breaking performances, but the results, on the whole, were satisfactory.

Outstanding were: Two good runs by Nel in the 100 and 220 yards, a splendid finish by Black in the mile, 2000 long-jumping by Akeroyd and Youngman, and a steady 3 miles by Garrod against a Middlesex champion.

RESULTS.

100 Yards: 1, J. G. Nel; 2, J. G. Youngman; 3, Hobson (S.). Time, 19½ sec. 1 yd., ¼ yd.
440 Yards: 1, Lawrence (S.); 2, C. P. C. Reilly; 3, W. H. Jopling. Time, 53 sec. 1 ft., 2 yds.
120 Yards Hurdles: 1, Bowler (S.); 2, W. D. Collart; 3, G. L. Way. Time, 17½ sec. 3 yds., 1 yd.
Javelin: 1, C. M. Dransfield, 142 ft. 6 in.; 2, E. E. Harris, 131 ft. 6 in.; 3, Pritchard (S.), 130 ft. 6 in.
3 Miles: 1, Nichols (S.); 2, O. C. Garrod; 3, Davidson. Time, 15 min. 51 sec. 25 yds., ditto.
Long Jump: 1, G. A. Akeroyd, 20 ft. 1 in.; 2, J. G. Youngman, 20 ft. 4 in.; 3, Steang (S.), 18 ft. 14 in.

High Jump: 1, Hart (S.), 5 ft. 2 in.; 2, G. L. Way, 5 ft.; 3, R. Mundy, 4 ft. 10 in.
880 Yards: 1, Lawrence (S.); 2, Pritchard (S.); 3, T. P. Storey. Time, 2 min. 12½ sec. 1 yd., 2 yds.

Weight: 1, D. R. Fraser, 36 ft. 11 in.; 2, G. D. Wedd, 35 ft. 9 in.
1 Mile: 1, Eccles (S.); 2, A. I. Kinnear; 3, K. O. Black. Time, 4 min. 46½ sec. 1 yd., 6 in.
220 Yards: 1, J. G. Nel; 2, Daw (S.); 3, Horn (S.). Time, 23½ sec. 2 ft., 1 ft.

Thus, at the moment, we hope to retain the Inter-Hospitals Championship, which we gained last year after a close struggle with St. Thomas's Hospital. Already the extra training facilities at Charterhouse Square reflect in the improved performances of our field events men by whom the team is consolidated.

The Hospital Sports this year will take place on Saturday, June 30th, at Winchmore Hill, to start at 14.30 hours. The President and Committee extend a hearty invitation to all members of the Hospital and their friends.

INTER-HOSPITAL ATHLETIC SPORTS, 1934.

St. Bartholomew's again won the Hospitals' championship on May 26th, scoring 56 points as against St. Thomas's 45 and Guy's 28. The Princess Marie Louise Cup for the best individual performance was awarded jointly to Reilly and Page. The British Medical Association Cup for the best all-round performance was again won by Reilly.

The results were:

100 Yards: 1, J. G. Nel (St. Bartholomew's); 2, L. R. J. Rinkel (St. Thomas's); 3, A. Heriot (King's). Won by a yard. Time, 10½ sec.
220 Yards: 1, J. G. Nel (St. Bartholomew's); 2, A. T. Marrable (St. Thomas's); 3, L. R. J. Rinkel (St. Thomas's). Won by 2 yards. Time, 23 sec.

Pole Vault: 1, K. W. Martin (St. Bartholomew's), 10 ft. 9 in.; 2, B. B. Botha (St. Bartholomew's), 10 ft. 6 in.; 3, R. S. Holtan (St. Thomas's) and C. J. P. Pearson (St. Thomas's), 9 ft. 4 in., equal.

Half Mile: 1, C. W. J. Clayton (King's); 2, H. Theakston (St. Thomas's); 3, R. Tilly (Guy's). Won by 4 yards. Time, 2 min. 3½ sec.
Putting the Weight: 1, A. J. Martin (St. Thomas's), 40 ft. 6½ in.; 2, D. R. Fraser (St. Bartholomew's), 39 ft. 9 in.; 3, G. D. Wedd (St. Bartholomew's), 38 ft. 2 in.

High Jump: 1, G. S. W. Organe (Westminster), 5 ft. 8 in.; 2, R. O. Verbury (Guy's), 5 ft. 6 in.; 3, J. Smart (St. Bartholomew's), 5 ft. 5 in.

120 Yards Hurdles: 1, A. Anderson (St. Thomas's); 2, P. Griffin (Guy's); 3, C. C. Jeffery (London). Won by inches. Time, 16½ sec.
Throwing the Javelin: 1, B. L. Prendergast (St. Mary's), 148 ft. 8½ in. (record); 2, C. M. Dransfield (St. Bartholomew's), 143 ft. 3 in.; 3, E. E. Harris (St. Bartholomew's), 129 ft. 5 in.

Quarter Mile: 1, C. P. C. Reilly (St. Bartholomew's); 2, D. Dutoit (Guy's); 3, A. Heriot (King's). Won by 10 yards; 1 yard. Time, 51 sec.

1 Mile: 1, B. H. Page (London); 2, A. E. J. Etheridge (Guy's); 3, K. O. Black (St. Bartholomew's). Won by 60 yards. Time, 4 min. 29½ sec. (record).

Long Jump: 1, G. W. S. Organe (Westminster) and R. E. Bonham-Carter (St. Thomas's), 21 ft. 9 in., equal; 3, A. T. Marrable (St. Thomas's), 21 ft. 7¼ in.

Quarter Mile Hurdles: 1, C. P. C. Reilly (St. Bartholomew's); 2, A. Anderson (St. Thomas's); 3, P. Griffin (Guy's). Won by 15 yards. Time, 50½ sec. (record).

Tug-of-War: St. Thomas's beat Guy's by two pulls to one.
1 Mile Relay (880, 440, 220, 220): 1, St. Thomas's (H. Theakston, A. T. Marrable, R. E. Bonham-Carter and L. R. J. Rinkel); 2, St. Bartholomew's, 3, King's. Won by 15 yards. Time, 3 min. 45½ sec.
3 Miles: 1, A. E. J. Etheridge (Guy's); 2, G. T. S. Williams (St. Bartholomew's); 3, A. Garrod (St. Bartholomew's). Time, 15 min. 19½ sec.

Champion Hospitals' Competition: St. Bartholomew's (holders), 56; St. Thomas's, 45; Guy's, 28; King's, 11; Westminster, 9; London, 7; St. Mary's, 6.

Princess Marie Louise Cup: C. P. C. Reilly (St. Bartholomew's) and B. H. Page (London) joint winners.

British Medical Association Cup: C. P. C. Reilly (holder).

TENNIS CLUB.

The 1st VI have played three matches, all of which have been lost. The first match on the Melbury hard courts was lost by seven matches to two, E. Corst and K. A. Latter being the only successful

pair. Against Queen's Club the 1st VI were again beaten by seven matches to two, K. A. Latter and B. Thorne-Thorne being the successful pair. The third match against R.N.C. Greenwich was lost by a depleted team by five matches to four. The results will no doubt improve as the amount of practice increases.

Out of three matches the 2nd VI have won one and lost two, winning against Northampton Engineering College, and losing to St. Thomas's and the London Hospital.

ASSOCIATION FOOTBALL CLUB.

ANNUAL GENERAL MEETING.

The following officers were elected for the season 1934-1935:

President: Dr. H. Hurtley.

Vice-Presidents: Sir Charles Gordon-Watson, Dr. A. E. Gow, Mr. Foster Moore.

Captain: D. R. S. Howell.

Hon. Secretary: C. N. Burnham-Slipper.

Hon. Treasurer: P. J. Hardie.

Captain 2nd XI: C. J. Carey.

Hon. Secretary 2nd XI: G. H. Darke.

Captain 3rd XI: A. G. Cunningham.

Committee: Captain, Secretary, Treasurer, and A. H. Hunt and J. W. B. Waring.

The sincere thanks of the Club are due to the untiring efforts of the retiring officers during the last most successful season.

HOCKEY CLUB.

At the Annual General Meeting held on April 23rd, the following were elected as officers for next season:

President: Dr. A. E. Gow.

Vice-Presidents: Dr. Geoffrey Evans, Mr. T. H. Just.

Captain 1st XI: J. M. Lockett.

Hon. Secretary: P. G. Hill.

Match Secretary: G. Blackburn.

Captain 2nd XI: A. D. Sharpe.

Secretary: T. M. C. Roberts.

Captain 3rd XI: A. M. Carver.

CRICKET CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. WANDERERS.

Played at Winchmore Hill on Wednesday, May 2nd, under ideal conditions.

The Wanderers lost the toss, and after Wedd had made them bat on a good wicket, put up the useful score of 109 in about three hours. Cochrane, Mundy and Dolly bowled well. With plenty of time in which to get the runs or get out, Bart's started poorly, and it was not until Capper joined Morison that things took a turn for the better. Capper did not quite know what to make of Wheathouse's slows at first, but soon began to see the ball and hit it really hard, passing the 30 mark before Morison, who had started with a substantial lead on him. Wedd knocked up a quick 20 to make the game secure, and the last men went in with the idea of scoring or getting out, chiefly resulting in the latter. An excellent game and a good start to the season to beat a strong team, which we have not beaten for many years.

Scores: Wanderers, 109.

C. R. Morison, c Parker, b Hawkins	81	W. M. Maidlow, b Hart	10
R. C. Dolly, b Hart	1	C. M. Dransfield, b Hawkins	0
G. W. H. Wade, b Wheathouse	10	W. T. Ross, b Hart	0
W. M. Capper, c Eland, b Hart	02	R. Mundy, b Hart	9
G. D. Wedd, b Hart	20	J. C. Cochrane, not out	1
J. D. Wilson, c Whittaker, b Hart	5	Extras	16
		Total	218

ST. BARTHOLOMEW'S HOSPITAL v. ROMANY C.C.

Played at Winchmore Hill on Sunday, May 6th.
Winning the toss, Romany batted first, but, in spite of a good wicket, found runs hard to get against the bowling of Cochrane and Mundy. They were all out after lunch for 96, which did not seem to be a very formidable total to beat. Robertson-Glasgow opened the bowling for the Romany, and with a strong wind behind him was bowling very fast and accurately; at teatime he was responsible for having put Bart's in the unenviable position of 6 wickets for 38. After tea, however, Mundy was joined by Maidlow, and both showed

that Robertson-Glasgow, if not to be hit, at least could be played. The winning hit was justly made by Mundy, a beautiful 6 into the tennis courts.

Robertson-Glasgow took 6 wickets for 24 runs.

Scores: Romany C.C., 96.

Bowling: Cochrane, 3 for 11; Dolly, 2 for 31; Dransfield, 4 for 13,	W. M. Maidlow, c Yglesias,	10
C. R. Morison, b Robertson-Glasgow	b R.-Glasgow	29
S. Littlepage, lbw, b R.-Glasgow	C. M. Dransfield, st Goodl, b Boyle	15
R. C. Dolly, c Mair, b Dearse	J. B. Bamford, c Gordon, b D. J. A. Brown, b R.-Glasgow	6
G. V. H. Wade, b R.-Glasgow	J. C. Cochrane, not out	0
J. D. Wilson, b R.-Glasgow	Extras	15
R. Mundy, c sub, b Yglesias	Total	143
Bowling: R.-Glasgow, 6 for 24.		

ST. BARTHOLOMEW'S HOSPITAL v. U.C.S. OLD BOYS.

Played at Winchmore Hill on Saturday, May 12th.

The U.C.S. Old Boys won the toss, and rightly decided to bat on a true wicket. Cochrane started well by bowling; two of their men in the first over. Cochrane and Wedd did most of the bowling, and with the aid of Dransfield and Dolly, kept the Old Boys fighting for runs, and at tea-time they had been dismissed for 123. Bart's did not start well, and Dransfield was the only batsman of the first four who looked as if he was going to score. It was not until Wedd had been in for half-an-hour that the game took a turn for the better. After a shaky start he settled down and began to hit the ball fairly in the middle of the bat, and when he was with Maidlow in a productive stand the game was virtually won. But the U.C.S. O.B.s., or the gods, or both, thought otherwise, for first of all Maidlow was rather foolishly run out, then Wedd appeared to throw his wicket away (to let the others have a knock!). The rest is best left unsaid, the explanation of failure in some cases, at any rate, being quite unexplainable. In no way detracting from Glanfield's excellent last two overs (in which he took 3 wickets for none), and Mackie's last over (in which he took 2 for none), Taylor and Moran must have felt wronged after having borne the brunt of the bowling so well for the greater part of the innings.

Scores: U.C.S. Old Boys, 123.

Bowling: Cochrane, 3 for 17; Wedd, 3 for 32; Dransfield, 2 for 8.	J. D. Wilson, b Moran	0
S. Littlepage, lbw, b Taylor	G. V. H. Wade, c Moran, b Glanfield	0
C. M. Dransfield, st Sharman, b Moran	W. M. Capper, b Mackie	0
D. J. A. Brown, st Sharman, b Moran	R. C. Dolly, not out	0
G. D. Wedd, b Mackie	J. C. Cochrane, b Glanfield	0
W. M. Maidlow, run out	Extras	5
	Total	121

SWIMMING CLUB.

The prospects of this season seem very bright, as the Hospital still has the services of the greater part of last season's team. Several newcomers may strengthen the team considerably, so that the Club now stands a very good chance of retaining its trophies, although a great deal of training will be necessary to bring the team up to scratch.

The United Hospitals' Swimming Gala will be held at Marshall Street Baths on June 30th.

ST. BARTHOLOMEW'S HOSPITAL v. POLYTECHNIC 1ST TEAM.

This match, the first of the season, was played at the Polytechnic Baths and proved a great success, although the Hospital lost. The Polytechnic are one of the best teams in the district and Bart's were able to turn out a strong side, which was just unable to hold the opposition.

The Hospital defended the deep end in the first half and were very slow in getting off the mark and tackling the opposing forwards. The defence was rather weak, so that Sutton had to do a great deal of extra work in order to strengthen the defence. Half-time came with the Polytechnic winning by 4 goals to nil.

The second half was much the same as the first, although at the start the forwards did show signs of better combination. Sutton was able to attack rather than to defend, so that the Hospital slowly reduced the lead. Towards the end the team slowed up

considerably, due to lack of training, and failed to hold their opponents in the last few minutes.

Result: Lost by 4 goals to 6.

Team.—G. S. Vartan, A. Orlek, B. H. Goodrich, R. J. C. Sutton, C. K. Vartan, J. C. Newbold, T. O. McKane.

ST. BARTHOLOMEW'S HOSPITAL V. OLD MILLHILLIANS.

This match was played at Fitzroy Baths and consisted of swimming and water polo. It was impossible to turn out a strong team, but the sides were well matched.

The swimming consisted of a 60 yards race, won by C. K. Vartan, with Saltman third, 30 yards, in which Dransfield and Brockbank were second and third respectively; and a team race, which was won by the Old Millhillians.

Result: Lost, 11 points to 14.

The polo match was a great improvement on previous games, and the team, although composed mainly of reserves, put up a very good show and gave glimpses of good combination, which had been noticeably absent from previous matches.

The Hospital won the toss and defended the deep end. Vartan began attacking from the start, with the result that two goals came early on in the game, both after a good movement between forwards and half-back. The Old Millhillians retaliated with one goal just before half-time. (Half-time, 2—1.)

The second half showed better team-work on the whole, both backs marking well and swimming through when possible. Moore scored a clever goal with a pass from Vartan, and Dransfield played a very safe game in goal.

Result: Won, 4—7.

Team.—C. M. Dransfield, G. S. Vartan, I. H. West, C. K. Vartan, P. Saltman, F. T. Moore, T. O. McKane.

RIFLE CLUB.

The season on the miniature range was brought to an end at the beginning of May.

During the season the "A" team have fired 36 matches and have won 27 and the "B" team 22 matches and won 12, making a total of 30 wins out of 58 matches fired—a very creditable performance. The following is a summary of the season's events.

The Lloyd Cup.

(Presented to the winner of the Inter-Hospital League Competition.) won by St. Bartholomew's Hospital.

This competition was re-started last season after a lapse of several years. Bart's now win it for the second year in succession with the proud record of having won all their matches in this league throughout the two seasons.

Engineer's Cup League.

After holding the leading position to within a few weeks of the season's end, Bart's were beaten into second place and lost the cup to Imperial College by 1 point. Eight teams competed, and of 14 matches shot, Bart's won 11 and lost 3.

City of London Rifle League.

In the final league table Bart's "A" were 4th in Division 7, in which 10 teams competed.

Matches fired, 18: Won 12, lost 6.

Bart's "B" were 5th in Division 13, in which 11 teams competed. Matches fired, 20: Won 9, drawn 1, lost 10.

The Bronze Medal, awarded to the member of each team obtaining the highest average of all scores made in C.L.R.L. matches, was won as follows:

"A" team: D. O. Davies; score 98'47.

"B" team: N. B. Mundy; score 96'00.

Individual Cup Competitions.

The following were finalists in the Lady Ludlow and Sir Holburt Waring Cup competitions:

Lady Ludlow.

Sir Holburt Waring.

D. O. Davies.

D. O. Davies.

J. E. Underwood.

L. R. Leask.

W. A. Owen.

W. A. Owen.

B. P. Armstrong.

J. E. Underwood.

G. E. Soden.

G. E. Soden.

H. Bevan-Jones.

H. Bevan-Jones.

G. C. Brentnall.

In both competitions D. O. Davies and J. E. Underwood tied for first place with scores of 99. In a second attempt to decide the issue both again made similar scores, but finally J. E. Underwood scored a possible (100), to become a worthy winner of both competitions.

Clay Disc Competition.

This competition was instituted this season, and took the form of a knock-out tournament involving rapid fire at clay discs. In a closely contested final round between G. H. Pickering and G. C. Brentnall, the prize of a Pewter Tankard was won by G. H. Pickering.

Practice on the open range at Bisleigh has now commenced and, it is hoped, will be continued up to the first stage of the Inter-Hospital Armatage Cup Competition in June, by which time the selected team should be able to give a good account of themselves.

CORRESPONDENCE.

YOUNG'S RULE.

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

"Were they not come as guests to a remembered room,
Those words . . ."

DEAR SIR,—The recent grateful revival of interest in Thomas Young has tempted me to return to a freshly written article (modestly described as a "note") by Dr. Ralph Bolton in this Journal (October, 1932, xl, pp. 11-14), in which he piously associates two eponyms with this meteoric genius: Young's Modulus of Elasticity and the Young-Helmholtz Theory of Colour Vision. It may be timely to suggest, and I trust it may not be trivial and superfluous, that many students and practitioners of medicine are accustomed to keep his memory green in yet another eponym: *Young's Rule*, which gives the dosage of drugs suitable for children below the age of twelve years.

I am,

Yours faithfully,

11, The Avenue,
Bedford Park, W. 4;
March 10th, 1934.

W. R. BETT.

REVIEWS.

SURGERY OF THE SYMPATHETIC NERVOUS SYSTEM. By GEO. F. GASK, C.M.G., D.S.O., F.R.C.S., Professor of Surgery, University of London, Director of Surgical Unit, St. Bartholomew's Hospital, and J. PATERSON ROSS, M.S.(Lond.), F.R.C.S., Reader in Surgery, University of London, Assistant Surgeon and Assistant Director, Surgical Unit, St. Bartholomew's Hospital. (London: Baillière, Tindall & Cox, 1934.) Pp. XII + 162. Figs. 43 (13 Plates). Price 16s.

Gaskell and Langley discovered our present knowledge of the anatomy and physiology of the sympathetic nervous system, and their labours were completed by the beginning of the present century.

This knowledge passed into current teaching, but apart from a few isolated instances nothing happened to draw attention to its surgical uses until the work of Le Riche in France, and Royle and Hunter in Australia. By these two widely distant sources the attention of all surgeons was drawn to the operations of "periarterial sympathectomy" for vascular and motile disorders of the extremities, and to "ranisectomy" for the alleviation of the spastic element in palsies of central origin. Both these uses of sympathetic surgery are now condemned because they are based on anatomical errors. Paradoxical as it may seem, the introduction of sympathectomy into surgical practice for wrong reasons led to its extensive adoption. The interest of the surgical profession was aroused and the uses and abuses of sympathectomy became widespread. It would be easy to compile a list of over one hundred names of diseases for which sympathectomy has been both advocated and practised.

This rush naturally led to a state of affairs in which some surgeons believed that almost anything might be accomplished by sympathectomy, while others declared there was nothing in it.

It was clear that the ebb and flow of the sympathetic fashion would continue unrestrained by real knowledge unless somewhere there was a centre with the organization and the interest to find out really what did occur. It so happened that Bart's had established its Surgical Unit, and one of the first problems that engaged its attention was this problem of sympathectomy.

The Unit soon discovered that a great many anatomical problems needed further scrutiny, and investigations were begun on the innervation of blood-vessels, the distribution of sympathetic fibres to the pelvic viscera, to the genito-urinary tract, and to the alimentary canal, especially the large bowel and the oesophageal-cardiac region.

Since the sympathetic fibres exercise a continuous constrictor influence upon the blood-vessels of the extremities, it is possible, by abolishing this influence temporarily, to obtain a measure of the activity of the sympathetic fibres, to assess how much they contribute to the patient's disease and how much relief may be expected from their removal. In devising apparatus for these purposes, in the collection and analysis of the information so derived, the Unit has been especially successful.

The performance of a sympathectomy operation requires a decision to be made as to where the sympathetic outflow is to be interrupted (preganglionic fibre, cell, post-ganglionic fibre, for instance), and how this is to be achieved. In the elaboration of the anterior approach to the cervico-thoracic cord, the proof that the chain is at least as low as the second thoracic ganglion is at the command of the surgeon, the rapid convalescence after this anterior dissection and its freedom from unpleasant sequelae the Unit has made another important contribution.

It is a pleasure to draw attention to these successes by our Surgical Unit. Important, however, as is its work as a centre of investigation, still more important is the fact that such work necessarily makes it an authoritative centre entrusted with the power of drawing the boundaries of sympathetic surgery. This it restrains in the merely sceptical, and encourages a proper appreciation in the merely surgical.

Our Surgical Unit is a recognized world's centre on the problems of sympathetic surgery. Public recognition of this has been forthcoming on several occasions. What it has found to be good and true in sympathetic surgery it now gives to the world in the present volume—a volume which is short, lucid, and based on the critical investigations of the authors.

THE PHYSICIAN'S ART. By ALEXANDER GEORGE GIBSON. (Oxford: The Clarendon Press, 1933.) Pp. 237. Net price 7s. 6d.

Unfinished fragments by great writers are as interesting as they are tantalizing. It is doubtful, however, whether the world has not lost, but, rather, gained by the various attempts to finish the manuscripts. Whatever the effect in other instances, Dr. Gibson has made here a valuable contribution to general medical literature in his expansion of John Locke's fragment, *De Arte Medica*. Locke had succeeded in getting little further than a statement of his object, which was to "consider—

"(1) The present state of the faculty of Medicine as it now stands in reference to Diseases and their cure"

"(2) The several degrees & steps whereby it grew to that height it is at present arrived to, wh I suppose are these following: 1. Experience 2. Method founded upon philosophy & Hypothesis. 3. Botanique. 4. Chymistry. 5. Anatomy. In all wh I shall endeavour to shew how much each hath contributed to the advancing the Art of Physick, & wherein they came short of perfecting it"

"(3) What yet may be farther done towards the more speedy and certain cure of diseases, i.e. By what means & method the practise of physick may be yet brought nearer to perfection."

Dr. Gibson does not adhere strictly to these objects, but gives a most wise and pleasant exposition of the ethics and methods of good practice.

He deals with the generalities first, and then passes on to details in the system and the address of the doctor himself. An indication better than any description, however, can be given by the simple setting forth of the list of contents:

- I. On John Locke's Fragment *De Arte Medica*.
- II. Art and Science.
- III. Of Diagnosis.
- IV. Of Prognosis.
- V. Of Treatment.
- VI. The Ethics and Management of Practice.
- VII. Of the Doctor Himself.
- VIII. Optimism.

And again, a few quotations can give an idea of the author's wisdom and mode of expression more clearly than any abstract:

"If the art of medicine can be learned by conscious directive effort apart from the ordinary routine of daily practice, then it

ought not to be left to haphazard methods; the course must be charted. The present study is based on the assumption that such an aim is not impossible; that in certain ways, not always current knowledge amongst doctors, a man's art may be improved, so that much of what is learned by experience may be made available for others."

"It is assumed then that to have been well grounded and properly trained in the science of medicine and to abide by the usually accepted principles of practice is not enough for developing the full power of the doctor's faculty. It is obvious also that neither the science nor the art of medicine can be acquired wholly from books; some men indeed never read books and yet acquire a considerable knowledge both of the one and the other; but book knowledge is a means of shortening labour, of refreshing the memory and of stimulating the imagination. A love of reading and a study of some portions of the world's best books cannot but assist in the widening of medical outlook."

"Relative value of signs.—In diagnosis one sign is not enough unless it is so marked as to be a chief sign. In slight signs two indications must converge or a clinical sign must be confirmed by a microscopical or laboratory finding. A positive Widal reaction is no proof of typhoid fever. More often, however, signs and symptoms require consideration before they can be fitted into the supposed course of a disease: it is then that we must seek for confirmatory signs, which some other part of the body, such as the fundus oculi, which has hitherto been omitted in the examination or examined carelessly, may provide. The real value of clinical pathology is to provide confirmatory evidence."

"Testing the method.—In order to bring out the true meaning of situations in which personal and other considerations may bias judgment, it is desirable to have certain tests, most conveniently in the form of questions. The most useful one is 'If this patient were my child, wife or mother, should I give the same advice as I am now going to give?', and another is 'Shall I be ashamed to acknowledge this advice as my own, and can I substantiate it if a colleague ultimately comes to have charge of the patient?'"

"Approach to patients.—Special thought is not ordinarily required for the approach to a patient, beyond adherence to the rules of good breeding, but it may sometimes be necessary when he must be encouraged to frankness, and his consent obtained for a full examination. Children demand this study, for they readily distinguish between those who are in sympathy with them and those who are not. There is a whole freemasonry of signs between children themselves and between some men and children. It is reported of a London doctor that when a child is brought to him he sits on the floor by the child while the mother sits on a chair near by."

"Optimism sustains.—The man to sustain the patient in an emergency and pull him through it must be an optimist, and if a doctor is not naturally one and wishes to be successful he must acquire the attitude; this is what many men do, much to the advantage both of their practices and their characters. 'A merry heart is a good medicine; but a broken heart drieth up the bones.' 'The spirit of a man will sustain his infirmity, but a broken spirit who can bear?' (*Proverbs*, xvii, 22, and xviii, 14)."

These quotations can give only a very dim impression of the whole book, but we have ourselves enjoyed and found food for thought in almost every sentence.

It is beautifully produced and written, and we have no hesitation in commending it to everyone who is anxious to get the best out of his calling.

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

- BLAIR, HENRY, M.B., B.S. (S. WATSON SMITH, M.D., F.R.C.P., and H. B.). "A Case of Starvation Hypoglycaemia." *Clinical Journal*, May, 1934.
- BRAMBRIDGE, C. V., F.R.C.S.(Edin.). "A Case of Lymphangioma of the Tongue." *East African Medical Journal*, December, 1933.
- (and TROWELL, H. C., M.R.C.P.). "A Case of Chronic Duodenal Ulcer in an African Native." *East African Medical Journal*, March, 1934.
- (and HOSKING, W. G. S., M.B.). "Note on an Unusual Case of Intestinal Obstruction." *East African Medical Journal*, March, 1934.

- CARMICHAEL, E. ARNOLD, M.D., F.R.C.P.(Edin.), and FRASER, F. R., M.D.(Edin.) (and McKEVELY, M.C., M.D.(Edin.), F.R.C.S.(Lond.), and WILKIE, D. P. D., M.D.(Edin.), F.R.C.S.(Eng.). "The Therapeutic Action of Prostigmin." *Lancet*, May 5th, 1934.
- COCKAYNE, E. A., D.M., F.R.C.P. "Congenital Pyloric Stenosis in First Cousins." *Lancet*, April 28th, 1934.
- CULLINAN, E. R., M.D., F.R.C.P., and GRAHAM, GEORGE, M.D., F.R.C.P. "Atheroma and Coronary Thrombosis in a Young Diabetic." *Journal of Pathology and Bacteriology*, March, 1934.
- DRURY, E. G. DRU, M.D., D.P.H. "Labels and Luggage." *South African Medical Journal*, March 24th, 1934.
- FRASER, FRANCIS R., M.D.(Edin.), F.R.C.P.(Lond.). See Carmichael, Fraser, McKelvey and Wilkie.
- GARROD, LAWRENCE P., M.D., M.R.C.P. See Hadfield and Garrod.
- GRAHAM, GEORGE, M.D., F.R.C.P. See Cullinan and Graham.
- HADFIELD, GEOFFREY, M.D., F.R.C.P., and GARROD, LAWRENCE P., M.D., M.R.C.P. *Recent Advances in Pathology*. Second edition. London: J. & A. Churchill, 1934.
- HAMMOND, T. E., F.R.C.S. "The Diagnosis and Prevention of Infections of the Urinary Tract." *Clinical Journal*, May, 1934.
- KETTLE, E. H., M.D., F.R.C.P. "Experimental Pneumoconiosis; Infective Silicosis." *Journal of Pathology and Bacteriology*, March, 1934.
- KEYNES, GEOFFREY, M.D., F.R.C.S. "Machon, or the Future of Surgery." *Lancet*, May 10th, 1934.
- KILNER, T. POMFREY, F.R.C.S. "The Thiersch Graft: its Preparation and Uses." *Post-Graduate Medical Journal*, May, 1934.
- LOYD, ERIC I., F.R.C.S. "Copper Strips for Splitting Plasters." *Lancet*, May 10th, 1934.
- MARSHALL, J. COLE, M.D., F.R.C.S. "The Causation and Operative Treatment of Detachment of the Retina." *Practitioner*, May, 1934.
- PARAMORE, R. H., M.D., F.R.C.S. "The Treatment of Puerperal Sepsis." *Medical Forum*, January-March, 1934.
- STAHLARD, H. B., M.D., F.R.C.S. "Glaucoma." *Practitioner*, May, 1934.
- UNDERWOOD, W. E., F.R.C.S. "Psychology in Infants." *Archives of Disease in Childhood*, April, 1934.
- WARD, ROY, M.B., B.S. "Cancer: with Special Reference to Early Diagnosis." *British Medical Journal*, May 19th, 1934.

EXAMINATIONS, ETC. University of Cambridge.

The following Degrees have been conferred:

M.D.—Evans, G. S. W.

M.B.—Lane, C. R. T.

B.Chir.—Houlton, A. C. L., Smart, J.

Conjoint Examination Board.

Pre-Medical Examination, March, 1934.

Chemistry.—Carroll, C. R. K., Carver, A. J., Messent, J. J., Moseby, W. G., Whittaker, W. O.

Physics.—Carroll, C. R. K., Carver, A. J., Messent, J. J., Morley, J. R., Moseby, W. G.

Biology.—Bower, R. A., Carroll, C. R. K., Carver, A. J., Corfield, C. C., Hardie, P. J., Hartill, G. G., Messent, J. J., Roberts, T. M. C., Whittaker, W. O., Williams, G. T. S.

First Examination, March, 1934.

Anatomy.—Barlow, A., Boden, G. W., Coates, H., Dalziel, J., Friedburg, W. K. S., Halford, R. B., Henderson, J. L., Stevenson, R. V., Wade, G. V. H.

Physiology.—Barlow, A., Boden, G. W., Dalziel, J., Friedburg, W. K. S., Halford, R. B., Henderson, J. L., Saltman, P. B. L.

Pharmacology.—Boden, G. W., Bones, A. O., Bloom, N. H., Clarke, S. H. C., Coates, H., Cole, M. J., Dalziel, J., David, J. E. A., Dolly, R. C., Dunn, R. W., Hughes, T. E., Littlepage, S. E., Macdonald, J. M., Nicoll, J. A. V., Ottley, M. F. B., Ringdahl, K. E. O., Young, W. J.

Final Examination.

The following students have completed the examinations for the Diplomas of M.R.C.S., L.R.C.P.:

Appelmann, M., Butters, A. G., Carpenter, R., Crosse, J. H. J., Daniel, T. M., Davies, H. G., Furber, L. B., Hamilton, G. J.,

Hulbert, N. G., Innes, A., Kanaar, A. C., Latter, K. A., Luinsden, K., Magdi, I., Martin, K. W., Martin-Jones, J. D., Moyrahan, D. J. M., Orlek, A., Roden, A. T., Selwyn, B., Soden, G. E. T., Stanton, H. G., Tooth, G. C., Weekes, C. R. H., Young, A. R. C.

Royal College of Physicians.

The following have been elected **Fellows**:

Cullinan, E. R., Lloyd, W. E., Varrier-Jones, Sir Pendrill.

The following have been elected **Members**:

Franklin, K. J., Harris, C. H. S., Hunt, J. H., Knox, R., Lane, C. R. T., Westwood, M.

Royal Colleges of Physicians and Surgeons.

The following Diplomas have been conferred:

D.O.M.S.—Patton, A. W.

D.P.H.—Lloyd, W. E. B.

D.P.M.—Laptain, J. H. R.

L.M.S.S.A.

Final Examination, April, 1934.

Surgery.—Joyce, R. G.

CHANGES OF ADDRESS.

BATEMAN, H. F., Lyghe, Shalford, Surrey.

EDELSTEIN, G. G. M., Sutton Scotney, Hants. (Tel. 67)

GALLOP, E., 163, Banbury Road, Oxford.

LOUGHBOROUGH, G. T., 41, Devonshire Street, W. 1. (Tel. Welbeck 8846.)

SINCLAIR, C. G., Bartholomew House, Lewes, Sussex.

APPOINTMENT.

BRAIMBRIDGE, C. V., M.V.O., B.Ch.(Cantab.), appointed Surgical Specialist, Kenya.

BIRTHS.

BAYNES.—On May 21st, 1934, at Reed House, Old Avenue, West Byfleet, Agnes Sarah (née Leay), wife of Dr. H. Godwin Baynes—a son.

COULVILLE.—On April 10th, 1934, at "The Old House", Ware, Herts, to Joan, wife of J. Robertson Couville—a son.

DE LABILLIÈRE.—On April 29th, 1934, at a nursing home, Plymouth, to Kitty (née Lawley), wife of Surgeon-Lieutenant C. D. D. de Labillière, Royal Navy—a son.

KERR.—On May 23rd, 1934, at The West Cornwall Hospital, Penzance, to Muriel Ingram (née Robb), wife of Dr. A. K. Kerr—a daughter.

LONGFORD.—On April 26th, 1934, at 20, Devonshire Place, London, W. 1, to Elizabeth (née Dunn), wife of Dr. W. U. Desmond Longford, of The Chestnuts, Rainham, Kent—a third son.

ROBINSON.—On April 20th, 1934, at The Cottage, Diss, Norfolk, to Gertrude, wife of Dr. Victor Penrose Robinson—a daughter.

SPACKMAN.—On May 21st, 1934, in a nursing home, to Kathleen (née Crisp), wife of Dr. E. D. Spackman, 46, Shelley Road, Worthing—a son.

MARRIAGE.

SCOTT—PRICHARD.—On May 1st, 1934, at St. Peter's Church, Bocking, by the Rev. H. A. Marshall, H. Harold Scott, M.D., F.R.C.P., to Eileen A. Prichard.

DEATHS.

COOK.—On May 4th, 1934, at 22, Newport Road, Cardiff, Mabel Mary (née Norton), beloved wife of Herbert G. Cook, C.B.E., M.D., F.R.C.S., aged 70.

SPREAT.—On April 24th, 1934, at Burrington, Oakleigh Park, Frank Arthur Spreat, F.R.C.S., aged 72.

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: National 4444.

St. Bartholomew's Hospital



JOURNAL.

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

VOL. XLI.—No. 10.]

JULY 1ST, 1934.

PRICE NINEPENCE.

CALENDAR.

Mon.,	July	2.—Special Subjects: Clinical Lecture by Mr. Higgs.
Tues.,	"	3.—Dr. Hinds Howell and Mr. Harold Wilson on duty.
Wed.,	"	4.—Cricket Match v. R.N. College. Away.
Fri.,	"	6.—Dr. Gow and Mr. Girling Ball on duty.
Sat.,	"	7.—Cricket Match v. Blackheath. Home.
Tues.,	"	10.—Dr. Graham and Mr. Roberts on duty.
Fri.,	"	13.—Prof. Fraser and Prof. Gask on duty.
Sat.,	"	14.—Cricket Match v. Shoeburyness Garrison. Away.
Tues.,	"	17.—Lord Horder and Sir Charles Gordon-Watson on duty.
Wed.,	"	18.—Cricket Match v. St. Ann's. Away.
Fri.,	"	20.—Dr. Hinds Howell and Mr. Harold Wilson on duty.
Last day for receiving matter for the August issue of the Journal.		
Sat.,	"	21.—Cricket Match v. St. George's Hospital. Away.
Tues.,	"	24.—Dr. Gow and Mr. Girling Ball on duty.
Thurs.,	"	26.—Cricket Match v. Midhurst. Away.
Fri.,	"	27.—Dr. Graham and Mr. Roberts on duty.
Sat.,	"	28.—City and Hospitals Charity Athletic Contest. Motspur Park, 3 p.m.
Tues.,	"	31.—Prof. Fraser and Prof. Gask on duty.

EDITORIAL.

WHILE we look for incorruption in the heavens, we find they are but like the earth—durable in their main bodies, alterable in their parts." Even in an institution blessed with the venerable antiquity of eight centuries we have come to expect and almost to ignore recurrent changes. The daily efflux of patients, the quarterly change of dressers and nurses and the biennial crop of new housemen have become so familiar that, with only a momentary sense of inconvenience or regret, we adapt ourselves without ado to the new conditions. As in our flesh, so here after a short space of time there remains but the shell and appearance of what was.

If time, circumstance and governing bodies withhold not their hands from even the structure of our Hospital, we cannot expect those to escape whom we

regard almost as part of it. There is always a shock, nevertheless, when we are told of the impending departure of a single member of the Senior Staff. They are giants also in these days. And the present generation at the Hospital has been very unfortunate in this respect.

It is difficult, therefore, to express our feelings when we hear of the coming resignation of two of the Professorial Staff, Prof. Fraser and Prof. Kettle, in order that they may undertake more responsible work at the new British Post-Graduate Medical School. We are thankful that the time to say farewell is not yet, and that there are still some months for us to become accustomed to the abstract idea before it becomes concrete fact at the end of this year.

In their voyage of exploration through that vast archipelago of medical research, St. Bartholomew's has been but a port of call. Proud that we have held them so long, we lose them to the more widespread gain of the profession. We continue to cherish the hope that in that vague and nebulous future some, at least, of us will sit once more at their feet.

Following on this comes the information that the Medical Professorial Unit is also to lose its Assistant Director, Dr. Hilton, who has been appointed Physician with Charge of Out-Patients at St. Thomas's Hospital.

Dr. A. B. Appleton (1911-1914), University Lecturer in Anatomy at Cambridge, has been appointed to the University Chair of Anatomy at St. Thomas's Hospital, in succession to Prof. Le Gros Clark.

The following have been appointed Examiners:
The Royal College of Surgeons.—Primary Fellowship: Mr. J. B. Hume, Anatomy; Prof. H. Hartridge, Physiology.

The Conjoint Board—Diplomas of L.R.C.P., M.R.C.S.: Mr. C. C. Hentschel, Biology; Dr. M. Donaldson, Midwifery; Dr. R. G. Canti, Pathology; Diploma in Ophthalmic Medicine and Surgery, Mr. R. Foster Moore; Diploma in Gynaecology and Obstetrics, Dr. J. D. Barris; Diploma in Dental Surgery, Mr. R. M. Vick; Diploma in Laryngology and Otology, Mr. Sidney Scott.

We regret that in the list of Bart.'s men holding office at the next B.M.A. meeting in Bournemouth the name of Dr. E. H. White, Vice-President of the Section of Medicine, was omitted.

Dr. A. M. Ware has been appointed a Knight of Justice in the Order of St. John of Jerusalem.

We have received the following encouraging letter from the Dean:

DEAR MR. EDITOR,

Since your last issue all old Bart.'s men have again been circularized on the subject of the College Appeal Fund. My main purpose was once more to give emphatic expression to my hope that the name of every old student of the Hospital would be on the subscription list before October 3rd, the date on which a banquet is to be held at the Mansion House for an Appeal to the general public.

As a result of my letter a further 67 Bart.'s men have sent me subscriptions, and many of those who had subscribed before have sent additional sums, raising the total of the Bart.'s donations to £26,719 2s. 3d.

On June 7th I was invited by the doctors in Worcestershire to attend a dinner at Droitwich to celebrate the fact that every Bart.'s man in the county had sent a donation to the fund. I was very pleased to attend, for it gave me an opportunity of congratulating them, and of telling them what was happening with regard to the scheme. They were delighted to know that their effort was likely to stimulate others to subscribe.

A further consequence of my letter has been that prominent men in several counties have offered to help us in getting the Bart.'s men together. But there are still counties that have no secretaries working in this way. Those that have are starred in the list of subscriptions. I should be very grateful if Bart.'s men in the other counties would volunteer to do likewise. I will gladly give them any information they may require.

Yours sincerely,

W. GIRLING BALL,

Dean of the Medical College.

(Subscription List on p. 189.)

The work of the Hospital painters seems interminable. They have just descended on R.S.Q. with their battery, pots to upset and trestles to prostrate, leaving innocent-looking walls to imprint an emerald streak on the unwary. The way was sufficient for the gaunt form of the weary district clerk on the third floor, but it proved too strait for some of the Staff on their way from the basement and the abundance of the Catering Company. Less respectful members of this gambling generation could be seen spending an entertaining post-prandial half-hour in estimating the chances of this one or that negotiating the Scylla and Charybdis of an uneasy trestle and a treacherous, painted wall.

We have seen some attempts in the Hospital to adopt the 24-hour clock. The only official venture to be modern has been the squaring of the time over His Majesty's head on the Gate. Perhaps the protracted and troublesome absence of the hands on the companion clock in the Square augurs a similar fate for it.

Many have thought that the modern student has too little leisure or inclination to participate in "rags" similar to those of the Good Old Days. Derby Day, however, saw a revival, though perhaps a mere ruin of forgotten times—the times of Fleet Street weeks and of borrowed guns. It was a small episode, but was not without its excitement for the few who witnessed it.

It also happened to be the street-collection day of a certain institution across the water. A group of white-coated dressers thought fit to ask for alms in the close vicinity of this Hospital. They were accosted by a party from Bart.'s, and in the flight that followed the arrival of The Law, one of the foe made the tactical error of running into the Abernethian Room. His emblems, an orange-coloured bucket and an arm-band, quickly found their way to a position of honour over the fireplace. He was only a small fish, and it was a pity that the gruesome threats connecting the fate of the intrepid explorer with the Fountain were spoilt by mere hooliganism and the temporary removal of collar and tie.

The sequel was amusing, although it left the score in their favour. Two of the foe, a few days later, took advantage of the safety of the large numbers in the A.R. to make a successful "smash-and-grab" raid on their property and made good their "get-away" in the usual waiting car.

The declining volume of material for the midwifery clerk is providing another problem for those harassed

with the arrangement of the curriculum. The reasons for the dearth of available maternity cases are many. The decreasing birth-rate and the exodus from slumdom are only partly to blame. Where material is plentiful, in the large maternity and municipal hospitals, a large part is being absorbed in the training of nurses and health visitors, the majority of whom do not intend to practise midwifery. The qualification of the Central Midwives' Board, however, seems to be required in applying for most posts in these days.

As a consequence, the clerk of to-day has little opportunity of personal management in the requisite score of cases. Making recently a minor investigation to illustrate the change, we chose, for the sake of interest, a member of the present Senior Staff who was a district clerk a quarter of a century ago. We found that in his month he himself attended 39 deliveries and he was one of six. During this past month there were "on district" five clerks who had each only 7 cases. This is above the present normal rate. Allowance must be made for the fact that the modern clerks do not hunt in couples, owing to the presence of the qualified midwives and the fear of too many cooks spoiling the birth.

In their enthusiasm and thirst for experience some have taken part of their course at one of the great maternity hospitals in London and in Dublin. They returned with a similar tale of many labours witnessed, but only a few personally managed owing to the presence of many pupil-midwives.

In an attempt to deal with the situation the Dean has arranged with two of the municipal hospitals (at Bow and at Camberwell) to accommodate a pair of students each for a fortnight. This is to be supplemented in most cases by a second period at St. Bartholomew's or on the District. The pioneers have returned, and the Dean and those concerned with him are to be congratulated on the success of the scheme. In one instance each conducted 18 labours in the fortnight, and to this was added the experience of a new hospital and of help in the routine work there.

For some, however, this will have to be a substitute for "District". Though there are many advantages in working in a new atmosphere, we feel that they cannot compensate for the loss of that sense of responsibility, insight and self-reliance in emergency that can be given only by the personal conduct of a case in the patient's home, humble and poverty-stricken though it may be.

It is the duty of every member of the medical profession to help his fellows and their dependents in old

age or poverty. Much can be done by subscription and as much by personal canvass. As an example of the scope for latter, a certain English city has been recently quoted as having five hundred practitioners, 450 of whom had a panel representing £180,000. Only 36 of these subscribed to recognized medical charities, and the subscriptions only totalled 40 guineas. The Royal Medical Benevolent Fund was established in 1836, and incorporated under the Companies Act in 1915.

The Fund exists as a general medical charity, and it is the desire of the Committee to enlist the direct sympathy and support of every member of the profession in order that the object may be efficiently and adequately carried out.

Its object is to assist members of the medical profession, their wives, widows and children who are in poverty and distress. Help is given in the form of annual maintenance grants, or in single grants to help over a particular difficulty or illness.

A number of annuities are provided for such persons who are aged or disabled.

In order to make the grants the Fund relies on annual subscriptions and donations.

Subscriptions are now urgently needed. Cheques should be made payable to the Honorary Treasurer, and sent to—

THE ROYAL MEDICAL BENEVOLENT FUND,
11, Chandos Street, Cavendish Square,
London, W. 1.

Legacies are needed for the Annuity Department.

PRIZE LIST, 1934.

<i>Hichens Prize</i>	No candidates.
<i>Kirkes Scholarship and Gold Medal</i>	G. W. Hayward.
<i>Senior Scholarship (Anatomy, Physiology and Chemistry)</i>	A. Jordan H. L. M. Roualle } Equal.
<i>Junior Scholarships (Anatomy and Physiology)</i>	1. D. V. Morse. 2. C. G. Fagg. A. Jordan.
<i>Harvey Prize</i>	J. E. Ennis.
<i>Foster Prize</i>	T. O. McKane E. H. Hambly } Equal.
<i>Treasurer's Prize</i>	D. V. Morse. R. J. H. McMahon. C. Huddleston.
<i>Bentley Prize</i> ("Diverticula of the Alimentary Tract")	D. W. Moynagh.
<i>Wix Prize</i> ("The Life and Works of C. B. Lockwood")	E. C. O. Jewesbury.
<i>Matthews Duncan Gold Medal and Prize</i>	A. Innes.
<i>Medal and Prize to Prox. Access.</i>	F. Avery Jones. R. L. Benison.

Brackenbury Scholarship in Medicine . G. W. Hayward.
 Prox. Access. D. G. ff. Edward.
 F. Avery Jones.

Burrows Prize A. Innes.
 Skynner Prize
 Brackenbury Scholarship in Surgery . E. W. Bintliffe.
 Prox. Access. G. Blackburn.
 Walsham Prize J. W. A. Turner.
 Willett Medal E. W. Bintliffe.
 Entrance Scholarship in Science . J. H. Gould.
 Entrance Scholarship in Arts and
 Jeaffreson Exhibition

Scholarship W. F. Simmonds.
 Exhibition I. Morgenstein.

The Old Students' Dinner will not be held this year. During the week usually appointed for that function an appeal is being made from the Mansion House for funds for the new Medical College. It is hoped that it will be possible to invite representatives of those old St. Bartholomew's men who have subscribed to the fund.

STOP PRESS.—We congratulate Mr. W. Girling Ball and Mr. E. Hey Groves on their election to the Council of the Royal College of Surgeons.

Congratulations also to the Swimming Club on their victory at the Inter-Hospitals' Gala.

The death of John Vaisey Newton Davis occurred very suddenly on June 19th. The news came with a shock to his teachers and fellow students, for he seemed perfectly well within a few hours of his death.

He was born on September 3rd, 1914. He was educated at Oundle School, where he spent four years and had a successful school career, doing well in his examinations. He represented his house at Rugby football and was also keenly interested in rowing. Entering St. Bartholomew's in October of last year he was studying for the 2nd M.B. examination at the time of his death. In his short time here he had made a place for himself in the College, and he was regarded by all as "a thoroughly good fellow".

Our sincere sympathy goes out to Lt.-Col. Newton Davis, of the I.M.S., and Mrs. Newton Davis, in the death of their only son.

NOTES FOR LECTURES ON DISEASES OF THE RESPIRATORY SYSTEM.

The following constitute some further extracts from Dr. Samuel Gee's lecture note-books.—HORDER.

PULMONARY INSUFFLATION.

THE Acute Emphysema of Fauvel, who was first to give an adequate description thereof.

Where the word Insufflation comes from I know not; it is attributed to Gluge, but I have not found it in his books.

Causes.

Occurs chiefly in children: ? because their chests are most easily acted upon by inspiratory muscles.

Acute dyspnoea: e. g. (connected with obstruction of windpipes). Cough has nothing to do with it.

- i. Suffocating Catarrh.
- ii. Croup: fatal croup always associated with capillary bronchitis.
- iii. Pulmonary Hæmorrhage causing death by suffocation.

The Attack of Asthma is probably productive of insufflation.

Lungs may be assumed to have been healthy before the attack of disease which caused the emphysema in children.

Theory of Production.

[The relative weakness of expiration is the chief reason why insufflation occurs in bronchial obstructions?]

The obstructions cannot be expelled, the lungs cannot be sufficiently emptied of air: nor can air be drawn past the obstructions. Obstructions are especially apt to occur in parts least affected by forced inspiration. Hence inspiration must be forced: feeling of want of air. Incessant forced inspiration dilates the chest beyond what the expiratory recoil can diminish: but not the whole chest, or not the whole chest equally. The distended chest necessitates a distended state of lungs.

Inspiratory muscles: Duchenne, pp. 901 sq.

Ordinary: diaphragm, intercostals.

Extraordinary: sternomastoids, scalenes; upper third of trapezii and splenii (these two as steadiers of the head).

Least important: serrati magni, pectorales minores, subclavii, rhomboids (Duchenne), omohyoids (S. G.).

STINKING SPUTA.

- I. Disease of Lung Parenchyma.
 - i. Gangrene.
 - ii. Phthisis pulmonalis: small slough in cavity or sequestrum formed in dense tuberculous consolidation.
- II. Disease of Air-tubes.
 - i. Bronchitis.
 - ii. Dilated tubes.
 - a. Many, with grey induration.
 - b. One, saccular.
- III. Disease of Pleura = Empyema.
 - i. Opening into air tubes: phthoe.
 - ii. Not so.
- IV. Disease of Bronchial Glands: abscess opening into air tubes.

NEW OPINIONS ON THE CAUSATION AND TREATMENT OF ANÆMIAS.*

BOYCOTT'S picture of the erythroblastic—that is, red cell-forming tissue—of the body, which he terms the "erythron", is most helpful in the understanding of the causation of the anæmias. The erythron, like other organs, consists of parenchyma and interstitial tissue. The parenchyma is the circulating red cells and the cells in the red marrow from which they are derived—endothelial cells, megaloblasts, normoblasts, reticulocytes and adult erythrocytes. The interstitial tissue of the erythron is the blood-plasma, the fat and reticulum of marrow. The erythron is entirely intravascular.

The presence of certain substances is necessary for the growth of the red cell stage by stage. The specific substance responsible for the change of endothelial cells into megaloblasts is as yet unknown, but its absence presumably leads to aplastic anæmia. In order that the megaloblast may develop into the normoblast, Castle's "intrinsic factor", which is secreted by the stomach and stored in the liver and kidneys, and Vitamin B must be available. For the normoblast to change into the erythrocyte, iron, copper, thyroxin and Vitamin C are required. Diminution or absence of these substances leads to impaired development of the red cells. When the supply of iron is deficient, either

* A lecture in the Post-Graduate Course given at St. Bartholomew's Hospital.

Note that all these act (like the intercostals) by dragging the ribs upward: so that forced inspiration tells only upon the upper and front part of lungs (S. G.).

Expiratory muscles: Abdominal (obliqui, transversales, recti), lower third of trapezii, latissimi dorsi (S. G.). These muscles are seen to contract in coughing.

Note how in hard coughing the strong contraction of the abdominal muscles straightens and depresses the lower part of the chest below the nipples. Hence violent expiration with closed glottis tends to dilate upper part of chest: the upper and front part of chest may be seen to dilate in this case. (Expiratory emphysema.) The mesochondriac bronchial fibres are powerful constrictors of the tubes, down even to those only $\frac{1}{4}$ mm. diameter.

Signs.

Bulging of chest in front:

Occurs in a few hours.

Lividity greater than in mere catarrh.

Prognosis.

The beginning of chronic pulmonary emphysema sometimes.

- i. Insufflation often repeated—asthma.
- ii. Acute catarrh becomes more or less chronic.

The persisting insufflation probably leads to degeneration of lung tissue, ? by means of anæmia.

Otherwise depends entirely upon the disease causing it.

PULMONARY ATROPHY.

Atrophous emphysema; i. e. in respect of the size of the lungs, their bulk is not increased.

All emphysema is atrophous in respect of destruction of lung tissue.

Mentioned by Fracaster, 1555.

Occurs under two conditions:

- i. General senile atrophy.
- ii. Arrested pulmonary phthisis: in younger patients. Past history thereof; perhaps physical signs even.

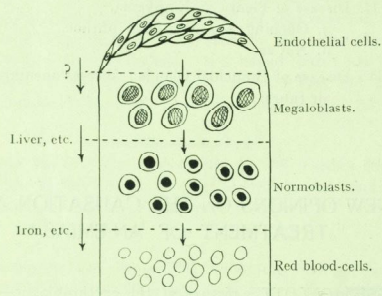
Signs and symptoms of hypertrophous emphysema, except that—

- i. Chest is not dilated: is inexpandible.
- ii. Lividity out of proportion to other symptoms.

Does not affect heart and general venous system so much as hypertrophous emphysema, probably because heart participates in general senile atrophy.

from unsuitable diet or from failure of absorption of the metal from the alimentary tract, normoblasts multiply in the marrow, and the erythroblastic tissue may invade the shaft of the long bones; but these cells do not grow up and the reticulocyte count is low, showing that few mature reds reach the peripheral circulation.

In health, except for a few reticulocytes, all the red cells in the peripheral circulation are mature. Reticulocytes, which number about 2% of red cells, can only be recognized by vital staining, which renders visible a network of remnants of basophilic cytoplasm of the immature cells. Their number gives a valuable index



to red cell formation. A megaloblastic reaction of the marrow is the result when the intrinsic factor, the nitrogenous complex derived from the gastric juice, is in abeyance and in consequence the number of mature red cells which escape into the circulation is low.

ADDISONIAN ANÆMIA.

The classical clinical account of this disease was published in 1855. Our knowledge of the condition has progressed by definite steps until at last it may be said to be mature. It was in Boston that the climax was reached, when it was shown that liver, stomach and kidneys contain a nitrogenous complex, formed by gastric digestion, which is curative in Addisonian anæmia. It is found that the gastric juice contains a ferment which is neither pepsin nor rennin nor HCl, and that this "intrinsic factor" produces from the food proteins a substance which is essential for the full development of megaloblasts into normoblasts. Anæmia is due to decreased formation or increased destruction of blood; this intrinsic factor stimulates the erythron to produce; it does not depress a hypothetical substance to destroy. In Addisonian anæmia, as pointed out by Hurst, achlorhydria is the rule: yet not all cases of achlorhydria suffer from Addisonian anæmia. Price-Jones showed

the average diameter of the red cells in this disease to be increased—it is a megalocytic anæmia.

Addisonian anæmia is not the only variety of megalocytic anæmia; important points in the differentiation of this disease from other megalocytic anæmias are signs of involvement of the central and/or peripheral nervous systems; high-grade bilirubinæmia as shown by the van den Bergh reaction, and increased bilirubin excretion.

The therapeutic technique of liver and stomach is now well known. Miss Abrahams will give you some hints as to how the former and its extracts may be made less unpalatable for administration. But it may be necessary to use intramuscular or intravenous injection of extract in an emergency—the hematitic principle is more active given parenterally than *per os*—or when nausea and vomiting prevent the administration of liver by mouth. There are many extracts on the market, and it is essential that the one selected should be active. In this Hospital, for intramuscular injection we use *Campalon* and *Hepatex I.M.*; for intravenous use, *Hepatex P.A.F.* The reticulocyte response is the measure of success in treatment; it begins to show itself in two or three days, and reaches the peak towards the end of the week.

Liver extract must not be used entirely to replace liver. Liver itself is rich in iron, and iron is required in Addisonian anæmia when a great increase in the number of red cells is taking place. Compared with liver the extract is expensive, but for those who can afford it, it may be given to vary the monotony two or three days a week. The extract of the liver of certain fishes is also active, and desiccated hog's stomach, which is put up under the name of "*Gastrexo*", may also be employed.

The amount of liver which is required to keep a patient suffering from Addisonian anæmia is about 240 grms. a day; many patients, however, require a much larger dose than this—even up to 800 grms., *i. e.* over 1½ lb. In such instances part of the dose may be given as liver and part as extract. Patients suffering from subacute combined degeneration of the cord require full doses both of liver and of iron. HCl is for the moment out of fashion, but my own view is that it is wise to give it according to Hurst's plan: the daily ration of acid, three teaspoonsful, is added to the juice of three lemons and one orange and made up to 15 oz. with water; brown sugar is added to taste—this may mean half a cupful. Of this, 5 oz. is taken fasting before breakfast, 5 oz. as the drink with lunch, and the remainder with dinner.

According to the newer terminology, Addisonian anæmia is called "primary macrocytic hyperchromic anæmia"—a name which sufficiently explains itself.

MICROCYTIC ANÆMIA.

Primary microcytic hypochromic anæmia is an example of an anæmia due to the defective absorption, or reduced intake, of factors necessary for blood formation—a disturbance of nutrition. Achlorhydria may be associated with perfect health, or, as we have seen, with a megalocytic anæmia, or if the iron metabolism is low, with anæmia of the microcytic type. Clinically this microcytic anæmia may resemble Addisonian anæmia in that glossitis, achlorhydria and splenomegaly may be common to both. But in microcytic anæmia no changes in the central nervous system take place; it is true that certain cases are associated with dysphagia, and these make up the Plummer-Vinson syndrome.

In this type of anæmia the colour index is below 1, and the van den Bergh reaction is negative, showing there is no increase in bilirubin in the blood-serum, and probably therefore no increased destruction of red cells. Females in the child-bearing period are particularly liable. The normal diet contains only a small excess of iron, which may easily be converted into a deficit if the diet be poor, and iron absorption interfered with by achlorhydria or the condition of the intestinal tract. The gastric juice contains Castle's intrinsic factor; there is therefore no response to liver in such cases, but they are curable by iron. We have already seen that the dose of liver required to maintain in health various patients suffering from Addisonian anæmia varies within wide limits, so also the dose of iron required to restore a primary microcytic anæmia to health varies greatly in individual cases. But while the sufferer from Addisonian anæmia must continue to take liver for the rest of his days, it is probable that in microcytic anæmia there is a time-limit to the treatment. The various preparations of iron are not equally efficacious, the ferrous salts being the most active. To give 200 mgrm. of ferrous iron a day requires gr. xxx of Bland's pill; the pill must be freshly prepared, and should be crushed or given in powder form. Cases which do not respond to such a dose may require much more, perhaps 90 or 120 gr. of ferri et ammon. cit. in the twenty-four hours.

Iron is of value in the treatment of those anæmias which show a deficiency in hæmoglobin; all chronic secondary anæmias resulting from chronic hæmorrhage; some cases of carcinoma of the stomach; some forms of metabolic disturbance, such as chronic renal and hepatic disease; diabetes and nutritional disturbances.

The anæmia of myxœdema, a deficiency disease, responds to thyroid; scurvy to the administration of vitamin C. Blood transfusion is the treatment for the acute anæmic breakdowns of later life.

A. E. Gow.

THERAPEUTIC DIETS IN ANÆMIA.*

FROM the dietetic point of view there are two main types of feeding for anæmia:

1. That for the Addisonian type of anæmia, where mere feeding with iron is not sufficient, liver, kidney, or liver extract alone being effective, with vitamins B (yeast, marmite, etc.) and C (fresh fruit and salads).

2. Diets for anæmias in which additional iron is required. Here iron medication will be materially assisted by high iron foods, such as liver, kidney, beef, eggs, black treacle, dried fruits, pulses, nuts, brown bread and cereals, spinach and other fruit and vegetables. It will be seen that these foods not only improve the iron content of the diet, but the protein, mineral and vitamin content as well.

1. *Addisonian type of anæmia.*—The patient will be expected to take ¼ lb. liver daily for an indefinite period. If the patient likes liver the problem is not too difficult. Liver can be served in any way that meat can, but is probably more effective if taken raw. (Recipes given below.)

Only people with hearty appetites can eat ½ lb. of liver at one meal. For the others it would be best to take ¼ lb. at two meals, varying these, as breakfast and lunch, breakfast and dinner, lunch and dinner, using different recipes at each. Kidney may occasionally be served as a change from liver.

For those who dislike liver, either the chemical extract can be used or Pickering's Liver Diet, or a savoury liver cocktail, which are taken as medicine three times a day. The patient can then take any kind of meals desired. Even for those who normally like liver this may form a pleasant holiday from liver at every other meal. Patients should not be expected to prepare raw liver dishes themselves, as they are rather messy and tend to spoil the appetite.

2. Food for the second group of patients with low hæmoglobin is far more attractive and varied than for pernicious anæmia, as attention is concentrated on the mineral salt and vitamin content of the diet, and not on liver alone. Unfortunately iron is found mostly in the more expensive foods, and on a very low-priced diet it is almost impossible to reach the 15 mgrm. which Sherman suggests as necessary for an average man. Women and children probably need more than a man in proportion to their size. The portions shown contain 1 mgrm. Fe each, so that 15 are needed for a day's supply of iron. It

* A lecture in the Post-Graduate Course given in St. Bartholomew's Hospital.

will be seen from the tables below that meats, eggs, black treacle, dried fruits, nuts, brown cereals and bread and fruits and vegetables are generally the richest sources, so that these should be secured in good quantities in the diet. The above provide vitamins B and C, but it should be remembered that vitamin C is destroyed on heating. It is safest therefore to be sure that all patients receive some raw fruit or salads, orange or tomato juice well strained being the most suitable source of vitamin C in the case of diarrhoea or digestive disturbances. As long as vitamin C is provided it is an advantage to serve vegetables in stews or soups or cooked in the minimum of water that will make them attractive on serving, so that the mineral salts may remain either in the vegetable, or in the stew gravy which is usually taken readily.

Nutritional anaemia may sometimes be due to an intake inadequate in quality or quantity, which can be corrected by making the patient's diet up to the normal requirement.

Many poor patients, and some others through taste, habit, or fear of indigestion, take a diet deficient in iron-bearing foods, such as fruit and vegetables, meat and eggs. By investigating patients' meals in detail they can very often be improved, giving due consideration to the patient's taste and purse.

If iron has to be added as cheaply as possible, imported ox liver, beef of any kind, eggs when cheap, dried fruits, raisins, dates, etc., and brown bread are suggested. Black treacle is excellent to increase the iron intake and as cheap as golden syrup. In calculating a low-priced, working-family's diet here, it was found that iron fell as much as 20% below an accepted standard.

Patients often miss one or two meals, or take diminutive quantities of food at meal-times without realizing that their intake is dangerously low. Iron intake is thus reduced along with everything else, although the types of food eaten may be excellent. Many women take no breakfast beyond a cup of tea, have a light lunch and tea, and sometimes do not eat much in the evening either. Sometimes they can be persuaded to add fruit or biscuits (wholemeal or gingerbread are best for iron) in the middle of the morning more easily than to take breakfast. Eggs are an excellent source of iron, and may be taken as a drink beaten up in milk, if possible, with a little black treacle, mid-morning, or as a night-cap. A good recipe containing about 3 mgrm. iron is to beat up an egg in 5 oz. milk and add ½ oz. black treacle. Olives, nuts and raisins all help the iron supply, and are not too filling. Using brown bread instead of white will double the iron intake from this source.

Children.—The best forms in which iron can be added

to children's diets are egg yolk, sieved spinach, and later, black treacle, minced liver, scraped beef, and stewed sieved prunes. For older children all the iron-bearing foods of an adult can be used, and the foods need not be sieved directly children can chew satisfactorily. The iron in milk, though small in amount, is probably in a form in which it is well used, and if a child takes its pint and a half of milk daily, it will receive over 2 mgrm. from this source.

It is surprising how little people notice the quality of the diet, and many anæmic patients, adults as well as children, may be helped considerably if they are persuaded to eat the full number of meals, and to include in them one or two foods rich in iron.

LIVER RECIPES.

PICKERING'S LIVER DIET: Wipe 8 oz. of liver. Mince, clean mincer and mince again. Add the juice of 2 oranges, 2 lemons and 2 oz. sugar and 2 tablespoons of port if liked to this liver; rub through a fine sieve or butter-muslin. Make the mixture up to 8 oz. with water if necessary. Take 3 times a day in equal portions. Water taken immediately after will remove any after-taste.

SAVOURY LIVER COCKTAIL: Mix 8 oz. of twice minced liver with half cup tomato ketchup, quarter cup lemon juice, 2 teaspoonfuls Worcester sauce, salt and pepper. Sieve, ice, and take in three doses.

FRIED LIVER: Wipe liver and cut in strips. Cook quickly till underdone in dripping. If served with bacon or onions, cook these first, frying liver in the same fat. In the case of onions, they will finish cooking with the liver.

LIVER STEW: Underdone fried liver cut in squares is used for the recipe. Use a tasty thick brown sauce with vegetables in it. Add liver squares just before serving and heat quickly.

TOMATO STEW: Thicken stewed tomatoes, fresh or tinned, or tomato ketchup and water, with cornflour or flour. Season well and add liver cut in squares just before serving.

CURRY: Make a sauce with the curry powder and serve the liver in this. Worcester sauce may be used instead of curry to flavour the sauce.

LIVER AND CHEESE SAUCE: Make a white sauce of milk and cornflour (½ pint to a dessertspoonful). Add grated cheese to taste (about a dessertspoonful). Put in liver when ready to serve.

LIVER AND HAM PIE: Chop up 2 oz. ham, mix with 8 oz. underdone liver cut in squares (with onions if desired). Place in pie-dish, add gravy, cover with pastry and bake.

MINCED LIVER: Fry liver till underdone, mince and serve in any sauce or mixed with tomato ketchup on toast.

STUFFED TOMATOES OR MARROW: Remove centre, or seeds. Fill with liver minced and mixed with tomato juice, Worcester sauce, a squeeze of lemon, herbs of any other flavouring. Bake in a slow oven.

LIVER SOUP: Season some stock well, adding Worcester sauce or marmite if liked. When boiling add raw minced liver and serve at once.

LIVER CUSTARD: Add liver minced or cut in squares to custard mixture (1 egg to 8 oz. milk). Place in pie-dish and bake in a pan of water in a slow oven for about 40 minutes until set. Cover with tomato ketchup or sliced tomatoes just before serving.

BACON ROLLS: Season minced liver well and form into rolls. Wrap in bacon, bake until bacon is cooked.

RICE MOULD: Grease a mould. Line with cooked split peas, rice or macaroni, fill up with raw minced liver. Cover with butter paper and steam for about 15 to 20 minutes in a saucepan with water coming half way up the mould. Turn out and serve.

CORNISH PASTIES: Roll out some pastry very thinly, cut into squares and place minced liver on these. Fold cornerwise, moisten edges and press firmly together. Bake in hot oven and serve with gravy.

RISsoles: Make a thick white sauce, using 1 oz. flour, 1 oz. fat to 1 pint milk. Mix this with well-seasoned minced liver. Spread on a plate until cooked. Form into rissoles, coat with egg and breadcrumbs and fry in deep fat until golden brown.

BROWN: Bring ½ pint well-flavoured stock to the boil. Take off the fire and dissolve in it 2½ sheets of gelatine. Add ¼ lb. liver cut in squares and a little ham to flavour if desired. Pour into a mould and allow to set. Turn out and serve with salad.

LIVER SANDWICHES: Season finely minced liver well with tomato ketchup or Worcester sauce for instance. Spread thickly on thin bread and butter.

TABLE I.

1 mgrm. iron contained in :

	Grms.		Grms.
Beef, topside, roast	11	Figs, dried	35
Egg, yolk	12	Prunes	35
Lentils	12	Raisins	35
Kidney, sheep	13	Cocoa	37
Black treacle	14	Spinach	39
Liver, ox, fried	14	Walnuts	48
Lean beef, steak, grilled	19	Peas, fresh	48
Liver, calf, fried	19	Cabbage	55
Oysters	22	Brown bread	62
Shredded wheat	22	Cheese	77
Hazel nuts	24	String beans	100
Cucumber	25	Potatoes	100
Currants	25	White bread	111
Almonds	26	Fish, haddock	143
Oatmeal	26	Apricots	167
Dates	28	Oranges	192
Egg, whole	33	Human milk	333
Watercress	34	Milk, cow's	417
Olives	34	Broth	667

References.—Sherman's *Chemistry of Food and Nutrition* (4th edition, MacMillan) for all figures except the following :

Meat and fish : McCance and Shipp, *The Chemistry of Flesh Foods and Their Losses on Cooking*, Medical Research Council.
 Broth : McCance and Widdowson, private communication.
 Human milk : Mackay, *Nutritional Anæmia in Infancy*, Medical Research Council.

TABLE II.—Chief Sources of Vitamins (Miss Harriette Chick, D.Sc.).

WATER-SOLUBLE.	
Vitamin B.—Complex.	
Vitamin B ₁ .—Anti-neuritic, anti-beriberi. (Heat-labile)*	
Yeast.	
Cereal embryos and bran.	
Liver.	
Egg yolk.	
Green-leaf vegetables.	
Orange.	
Vitamin B ₂ .—Anti-dermatitis, ? anti-pellagra. (Heat-stable.)	
Yeast.	
Liver.	
Eggs (yolk and white).	
Green-leaf vegetables.	
Meat.	
Milk.	
Vitamin C.—Anti-scorbutic. (Heat-labile at cooking temperatures. Destroyed by alkalis.)	
Citrus fruits (orange, lemon).	
Green-leaf vegetables.	
Some root vegetables (swede turnip).	
Fresh meat.	
Fresh milk.	
Germinated cereals and legumes.	

* Stable at ordinary cooking temperatures.

MARGERY ABRAMSHAM.

COLLEGE APPEAL FUND.

SUBSCRIPTIONS TO DATE.

	£	s.	d.	*
Staff	12,662	5	10	(71)
Demonstrators	1,685	1	0	(67)
Students	765	6	5	(287)
Old Bart.'s men :				†
‡Bedfordshire	23	1	6	(26)
Berkshire	121	1	0	(15)
‡Buckinghamshire	76	19	0	(20)
‡Cambridgeshire	176	4	0	(15)
‡Cheshire	4	14	6	(3)
‡Cornwall	31	11	0	(8)
Cumberland	5	0	0	(1)
Derbyshire	19	14	0	(4)
‡Devonshire	558	15	0	(52)
‡Dorset	52	1	0	(14)
‡Durham	16	6	0	(3)
Essex	253	2	6	(20)
‡Gloucestershire	215	5	6	(22)
Hampshire	435	8	0	(43)
‡Herefordshire	13	3	0	(4)
Hertfordshire	84	11	0	(10)
Huntingdonshire				(1)
Isle of Wight	181	13	0	(12)
‡Kent	563	3	0	(65)
‡Lancashire	91	4	6	(12)
Leicestershire	136	15	0	(7)
‡Lincolnshire	53	12	0	(14)
Middlesex	385	6	0	(21)
‡Norfolk	167	15	6	(21)
‡Northamptonshire	59	4	0	(5)
‡Northumberland	101	1	0	(2)
‡Nottinghamshire	19	19	0	(3)
‡Oxfordshire	185	3	0	(18)
Rutland				(2)
Shropshire	35	9	0	(8)
‡Somersetshire	1,024	10	0	(25)
Staffordshire	194	18	0	(6)
Suffolk	288	15	0	(21)
Surrey	447	19	6	(50)
Sussex	296	16	0	(57)
Warwickshire	178	1	6	(18)
Westmorland	2	10	0	(1)
‡Wiltshire	97	11	0	(11)
‡Worcestershire	160	0	6	(24)
‡Yorkshire	271	5	6	(22)
Wales	59	7	0	(150)
London	2,856	6	8	(185)
Channel Islands	10	0	0	(9)
Scotland	14	4	0	(4)
Abroad	48	5	0	(7)
South Africa	326	10	6	(17)
Canada	113	2	6	(8)
East Africa	72	7	0	(8)
West Africa	146	10	0	(5)
India	182	0	0	(8)
Ceylon	4	0	0	(1)
Syria	2	2	0	(1)
U.S.A.	5	0	0	(4)
Ireland	14	14	0	(3)
North Africa	1	0	0	(1)
North Borneo	5	5	0	(1)
Australia	17	2	0	(4)
Friendly Islands	1	1	0	(1)
Egypt	4	2	0	(2)
Malay States	4	6	0	(2)
China	46	8	4	(8)
Siam	10	0	0	(1)
France	50	0	0	(1)
Trinidad	22	2	0	(2)
British West Indies	23	1	0	(3)
New Zealand	2	1	0	(2)
Services.	534	3	0	(37)
Others	32,038	8	7	(306)
	£58,757	10	10	

* Number of Bart.'s men subscribing.

† Number of Bart.'s men in County.

‡ Counties with Secretaries.

EUTHANASIA: THE WAY OUT.

ET me tell you how I first met the Professor. I was walking in Richmond Park. It had been very hot, and now, with evening, came a welcome respite from the discomforts of the day. I walked along leisurely, at peace with the world, humming a tune. Suddenly, from the shadow of a great oak, sprang the queer figure of an old man. He wore a black sombrero hat, a black cape danced from his shoulders, and his trousers, imperfectly suspended, bagged considerably above his large and shapeless boots. His face was cadaverous, and he wore a straggling white beard. His nose was long and thin, like the beak of a bird; but what struck one most about him was the peculiar fascinating quality of his eyes, which glowed like living coals from their deep-sunk sockets.



"SPRANG THE QUEER FIGURE."

I stopped dead. He laid a claw-like hand on my arm, opened his toothless mouth, and emitted an eerie cackle that, somehow, sent a little shiver up my spine. Then he spoke, and his voice had a vibrant quality which belied his general air of decrepitude.

"You sing," he said, "because you know nothing of the great danger which threatens mankind. You look around you at the trees and the sky, and the whole tawdry vulgar display which Nature puts before you; you drink in the air which burns you up at every breath, and you feel glad to be here in this best of all possible worlds." He seized my arm and drew me into the shadow of a group of trees. He fixed his burning eyes on mine and continued:

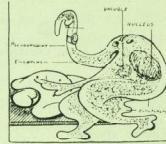
"Nature is your greatest enemy, I tell you. She cares nothing for the individual, only for the race. Wars, starvation and disease wipe out millions, with as little consequence as the crushing of an ant-hill. Civilizations rise and fall, even as this so-called civilization of yours is falling. Already the rot has set in. The economic systems of the world have broken down; the established order of things is being overthrown. Already a lower type of man is threatened in Europe and a new race is heralded, prognathous and anencephalic, which is to rule the world. Soon all will be chaos." I tried to speak but, somehow, the words would not come; I could only listen in a stupefied way as he continued:

"History will repeat itself. Mankind will sink to greater and greater depths of decadence. Then will come Armageddon and the obliteration of mankind by his own hand. A new Ice Age will begin. The

temperature of the earth will fall; slowly the icy borders of the Poles will creep towards the temperate zones. All life will be extinct.

"Then Nature will evolve a little amoeba, which she will cherish and foster throughout aeons of time until, in the end, a new race of men will be born to suffer in turn.

"Mankind must revolt," he suddenly shouted. "There is a way out—euthanasia!" Without a word of warning the crazy creature turned about, and, leaping and gesticulating, was soon lost to sight behind a belt of trees. I went home to bed and dreamt I was an amoeba, and discovered how hard it was to percuss a chest with pseudopodia instead of fingers.



"DREAMT I WAS AN AMOEBRA."

Two evenings later, when I had somewhat recovered from the shock of my strange encounter, I was seated in my favourite armchair with a pipe and a book, when Mrs. Miggs, who "does" for me, came in and said, "There's a person outside wishes to see you, and a queer cove 'e is too, fair gives you the creeps!" I was about to say, "Tell him I am not in," when a black sombrero hat appeared above Mrs. Miggs's shoulder. She turned round, saw the Professor, uttered a shriek and ran out as fast as her legs could carry her. I sat still in my chair, absolutely stunned. He came and sat close to me, his eyes glaring into mine.

"Perhaps you wonder how I came to find you," he said. "Never fear, I had no intention of losing you!" He fumbled in his pocket and produced one of my visiting cards which, I suppose, he had filched from my pocket in the park.

"Mankind must revolt," he said, as if he had never left me; "already he is revolting unconsciously. Already he is not so tethered to the earth as he formerly was. In his aeroplanes he is defying the forces that hold him down. He is penetrating the stratosphere. Nay, more, he is in communication with the spirit world; he is learning how incomparably more beautiful is life there than upon this poor earth of ours." He came closer, his voice more urgent.

"This is what we must do," he said. "We must drop all our preconceived notions of life, all earthly ambitions. Above all, we must not fear death. We must welcome it. We must not wait for it to overtake us; we must woo it as a maiden woos her lover. Do you know what euthanasia is?" I started and managed to gasp, "Isn't it some kind of tooth-paste?" He appeared not to notice me. He continued, "Eu"—

easy, 'thanos'—death; easy death. Not death coming in a thousand dreadful shapes, but death soft and beautiful as a song and tremulous as the flutter of the wing of a bird; an ecstasy; a sublimation of the soul; a sweetness too great to be borne.

"Children must be taught that death, not life, is desirable. Euthanasia clinics must be set up such as I already have in Prague. Think what it would mean—a cure for all social ills! Of what account, for instance, would disease be? Who would stay in a burning house with the door to freedom wide open? It would mean the end of your medical profession. Harley Street would be a wilderness. A new form of emigration would arise. Rejoicing would accompany each new departure for the higher plane of existence. Our souls are indestructible. Against a mass emigration from earth, Nature would be powerless. Her creatures have often tamed her in order to live; this would be the final defeat of Nature and the everlasting triumph of mankind."

"You aren't advocating mass suicide?" I managed to gasp. "We shall have a new idiom," he replied. "To remain incarcerated in these vile bodies will be death; to struggle free into the empyrean—that will be life. I will come again; I need your help." He arose, stroked my shoulder lovingly, cackled hollowly, and was gone before I could recover my senses. That night I did not sleep at all. I turned the extraordinary interview over and over in my mind. He would come again! He needed my help!

I was thankful when the first shaft of daylight came in at the window.

The next few days I spent in considerable apprehension and uneasiness of the spirit. The sinister face of the Professor was never quite out of my mind. As evening approached a feeling of oppression descended on me, and a most unpleasant sense of foreboding. Before retiring to bed I carefully bolted all doors and windows—a thing I had never troubled to do before. However, several days passed and I did not see the Professor although, on a number of occasions, I had the impression I was being followed; but this may well have been imagination.

Then one night, having carefully locked up, I went to bed and read for a while by the light of a reading-lamp. After that I must have fallen asleep. I was awakened, suddenly, by a sharp prick in the arm. I sat up, pale as a ghost, every nerve in my body taut. I tried to cry out, but my tongue clove to the roof of my mouth. A dark shape receded quickly and crouched in the shadow at the other end of the room. I was struck motionless by fear. For a minute all was quiet, then from the gloom came an eerie laugh, which seemed

to freeze the marrow in my bones. With fascinated horror I watched a dark shape move nearer and nearer into the narrow circle of light from the lamp, and I found myself gazing into the emaciated face and burning eyes of the Professor. He came nearer, eyes glaring into mine and spoke:

"Several nights I have tried to come in, but the doors and windows were fastened. To-night I came earlier. I was behind you as you went round locking up your house. But you need not fear me. I am your friend, the friend of the human race.

"Have you ever heard the expression, 'to die of joy'? A number have achieved this through me. In my native Prague I have a secret clinic where people come to me and beg me to grant them euthanasia. They put themselves in my hands without reserve or conditions, and their end on earth has indeed been beautiful, ecstatic; they have literally 'died of joy'. Let me tell you about some of my cases.

"The first was a musician, a man of exquisite taste and sensibility, a composer of renown. He was weary of the world, and longed for the peace and tranquility of the higher life. I knew him for an ascetic divorced from the coarser pleasures of this earth. Only through his sense of hearing could his mind be stimulated to undreamt-of heights of happiness.

"I put him into an empty room in the middle of a large house, and proceeded to sensitize him to beautiful sounds by the production of vile discords. I hired the *prima donna* from the neighbouring opera house to shriek coloratura passages at him from 'Il Trovatore'; navvies to break concrete with pneumatic drills outside his window. I hired an American from Oshkosh, Wis., to recite Shakespearian blank verse to him; an orchestra to play excerpts from Schönberg and Hindemith with the strings keyed a semi-tone above each other. I spared no expense. During all this time there were signs of increasing irritability and excitement. He walked up and down, his face pale and drawn. Beads of perspiration stood out on his forehead—a man in an acute agony of the spirit. But, strangely enough, it was a little thing that caused him completely to collapse. I engaged a small girl to play incessantly the Prelude in C sharp minor of Rachmaninoff on a boarding-house piano. The process of sensitization was complete; he lay on the floor, a mass of quivering humanity.

"For a few minutes all was still. Then, faint on the air, came a single trilled note from a flute. A spasm shook him from head to foot; his eyes dilated. Another



"AN AMERICAN FROM OSHKOSH, WIS."

silence, then, a cascade of descending arpeggios on the harp. His respirations became more rapid and his face flushed. His eyes were fixed on the blue of the sky outside. Then from a distance came the sound of muted strings playing a Mozartian air, mingling with the plaintive sounds of clarinet and oboe. He stood up, swaying, a look of ineffable joy on his face as the music throbbed in infinite sweetness. The music came to an end. There was the sound of a fall. The musician was dead. I suppose you doctors would call it a case of psycho-anaphylaxis.

"I could quote many similar cases. There was the case of the stockbroker, for instance, whose passion was oysters. I confined him in a cell from August 31st until April 30th. On the 30th of April (the last month with an 'r' in it) I allowed him to run amok in a West-end oyster bar. The look of heavenly repletion on his face when he died. . . . !

"But these experiments are tedious and costly, and could have no universal application. To achieve euthanasia for the masses something more simple had to be discovered. With the help of my colleague, Dr. Strabismus, of Utrecht—(Ha! I see by your start that you have heard of him)—I have evolved a complex substance which I have called 'euphorine', from its power of promoting euphoria or sense of well-being. By experiments on anthropoid apes I have ascertained that there is a definite 'happiness centre' in the brain, situated between the corpus striatum and the blue nucleus. Euphorine stimulates this happiness centre, sufficient dosage producing such delirious joy that the soul in its ecstasy can no longer contain itself within the narrow confines of the body.

"Hitherto in my earlier crude experiments my subjects have been old men, diseased, enervated and disillusioned. Now I come to the young with my wonderful offering; children, lovers, sweet maidens and strong young men, as yet untouched by life. So shall they be spared the miseries of existence. Thus shall we help posterity, in that there will be no posterity. I was attracted to you when I first met you in the Park; so young and strong, and with a song on your lips. I said to myself, 'He shall be in the vanguard of the great Rebellion against Nature. He shall know euthanasia, and start the movement to depopulate the earth and end, for ever, the whole vicious circle of evolution!'

He advanced nearer, a hypodermic syringe in his hand, a fanatical glitter in his eyes. "Come," he said, "abandon care; know joy; renounce this vile clay that weighs you down." I felt the point of the needle in my arm, and, suddenly, my senses returned. I jumped up, dashed the syringe from his hand, and struck

him a violent blow in the forehead. Then I dashed out into the street, where I was found, a gibbering idiot, by a passing policeman.

Later the inspector with a number of men visited my house. The Professor was still lying on the floor. When he saw the uniformed men he jumped up and fought like a tiger; but he was overpowered. He was taken to the station and was later identified as Prof. Crzeh (pronounced as in coughing), but better known as "Suicide Sam", a dangerous lunatic, who had escaped from an asylum and who had evaded capture for over a fortnight.

JOHN LONDON.

CONTRACT PRACTICE IN SOUTH AMERICA.

WHEN one has grown accustomed to sun-helmets, beachcombers, exotic drinks and the general Somerset-Maughan atmosphere, then contract practice in the tropics turns out to be much the same as it is in, say, Hornsey.

But that is not to say that such practice does not offer many advantages and a few pitfalls that are absent at home, and it is the object of this article to point out some of these.

The type of practice referred to is that offered by companies operating mines, oilfields and so on, which employ native labour and a British staff, including one or more medical officers. Essentially such work is for the young man, and should not be regarded as a permanency. If one stays too long the *dolce far niente* climate, restricted friendships, and maybe the attractions of the bar, sap one's enthusiasms and make one stale. But for a recently qualified man who lacks self-confidence it is a wonderful finishing school. There is probably no second opinion within call, and besides being "physician, surgeon and accoucheur" to the community, one is all the specialists, and often, at the last, undertaker and reader of the burial service as well. Dentistry and veterinary work may be side-lines.

Salary, as a rule, is good, varying from £500 to £800 p.a., with quarters and food allowance for a man who has just completed his house appointments. A car or a horse, whichever may be the means of transport, would, of course, be provided, and practically speaking the expenses of an unmarried man are limited to what he spends in the Club. There is often, also, some opportunity for private practice, though this is seldom large.

Contracts are usually for three years, with free passage from and to England, with six months' leave on full salary if the contract is renewed.

A word of warning is in place here that it is worth a lawyer's fee to have an opinion on the terms of the contract. It is drawn up by a lawyer to protect the company, and it may contain clauses grossly unfair to the employee. For the same reason, although the Medical Defence Union does not conduct cases abroad, membership is quite as necessary as it is for the man at home.

The question of obtaining the medical degree of the country is not likely to arise, unless one does much private practice in a neighbourhood where native practitioners are working. There is reciprocity in many South American countries as regards medical degrees, but the examinations are nowhere easy for foreigners on account of the language difficulty. Englishmen, as a whole, however, are such poor linguists that ignorance of Spanish is no bar to obtaining the post in the first instance. In practice, too, the language problem is not a serious one; with the help of "Hugo" and memories of schoolboy Latin one can learn sufficient in a month to carry on without an interpreter.

Not that one does not occasionally make painful mistakes. The writer, for example, once ventured to cavil at a mother's description of her nearly middle-aged daughter as a *niña* without realizing that the word can mean not only "child", but "virgin". Subsequent explanations were difficult. On another occasion he complained that a patient, who unknown to him was also attending a native practitioner, had caused him to be embarrassed. The roar of laughter that greeted the rebuke was not because of the patient's ignorance of medical etiquette, but because *embarrasado* is a euphemism for "pregnant".

But though the Spanish-Indian half-castes that formed the bulk of one's practice laughed at one's mistakes, it would have been fatal to have laughed at theirs. More often one was inclined to weep.

The belief in the Evil Eye was as firmly rooted as their objection to sanitation, and sympathetic magic formed a great part of their home treatment. There was, for example, an old Fishing Indian with a senile cataract who was found to be secreting match-heads, as sources of light, beneath his eyelids. The reasoning of the "gamp" who made her victim in difficult labour squat over a hen's egg appears obvious, but whether it can be classed as sympathetic magic seems doubtful.

It has often been a source of wonder by what accident our ancestors obtained their knowledge of out-of-the-way drugs. Perhaps it can be explained by the mental attitude of the Peruvian *cholos* towards treatment. It stands to their reason that everything must be a cure for something, and it only remains to discover the disease which fits the remedy. Thus, the liver of a fox

cures rheumatism, the heart of a skunk is specific against epilepsy, and inunction of the peritoneal fat of iguanas disperses tumours. And the process is still going on; within a year of the time that an English ornamental foliage plant was first introduced into the *gringos'* gardens natives were stripping them of their red leaves to treat their post-malarial anaemia.

It is not astonishing, then, that they have discovered the virtue of crocodile-liver oil in cachexia; incidentally, as prepared by the natives, one got better results from it than from ordinary commercial cod liver oil.

BURGESS BARNETT.

A POET ON MEDICAL THEORY.

AMUEL TAYLOR COLERIDGE'S interest in medical science, and especially in the theories of John Abernethy, is known to all readers of his *Theory of Life*. But the following autograph fragment, found among the Coleridge manuscripts in the British Museum, has not, I believe, been published, and it may be of interest to some of your readers in connection with the approaching centenary of the poet's death. The paper bears the watermark 1820.

"Hippocrates taught, and in a certain sense, with great truth, that the Art of Healing must be learnt from the practice of Healing. Later Physicians added the word, *exclusively*; and the sect of Empirics commenced: and it was assumed as a fundamental truth, that in order to the just discharge of medical duties the one and only thing necessary in each and every case was, that the Physician should recollect from his own experience or that of others what had been successfully tried in former cases of the same kind and species. And doubtless, if all cases of Disease could be as safely reduced to kinds and species, as the metals or even as plants; if the differences occurring in individuals were as slight and non-essential as are observed in different specimens of the same Ore; and if, lastly, Medicine were an insulated Trade, unconnected with physiology and liberal Science; this mode of procedure might be tolerably adequate to it's immediate Objects; until a new genus or species should start up. But alas, the same boasted experience, to the name of which the Empirics laid exclusive pretensions, compels us to know, that in the arrangement of Diseases under genera and species the memory of the Learner is far more consulted than the *bona fide* existence of the same in Nature—that in each several case we are to calculate on a Variety, nay, to be prepared for Varieties, that in the present state of the art are of more practical importance than the supposed Genus, under which it may be the fashion to subordinate it"

The next sentence I hesitate over including, as it needs a long breath; but it makes its point, and to those who know the "parentheses within parentheses" of Coleridge's prose style, it offers excellent evidence of authenticity:

"The easiest way, however, of considering this proposition will be to enquire what is or can be meant by the term, Experience—and if we should succeed in forming a clear conception of this, what are the conditions and necessary means of attaining Experience rightly so called; then to ask, by what right this Experience is to be confined to one particular state of the living Body, namely, that

of Disease—and lastly, to weigh the possibility of this very state, in itself severed by no chasm from the other, being sufficiently understood to be even recognized, when it occurs, with sufficient discrimination as to render the application of any former experience applicable, without the previous knowledge of that, it's difference from which constitutes it's very character, and generic distinction—namely, the state & structure of the living Body in it's healthful & in this sense it's natural state."

The fragment continues with some rough notes for a definition of experience as "seeing intellectually", and a description of the education that medical students bring to their hospital work.

Alice D. Snyder.

STUDENTS' UNION.

CRICKET CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. METROPOLITAN POLICE.

Played at Leyton Sports Ground on Saturday, May 19th. Bart's opened the innings on a pitch which looked as if it would soon crumble for want of rain. After a bad start, 2 wickets falling for 11 runs, Wedd once again came to the rescue with a characteristic 44 made out of 60, while Brown continued to bat very steadily at the other end. With Wedd out the rest of the side, which should be good for a large number of runs, gave a very good imitation of their performance of the week before, when 6 wickets fell for no runs against the U.C.S. Old Boys, and the whole side was out for 127 (which coincidentally was the same score as in the above-mentioned match). It was encouraging to see Brown get some runs, as he had been very unlucky in previous matches, two or three times being the unfortunate individual who has received the one ball of the match which would have bowled anyone.

When the Metropolitan Police batted, it was soon obvious that they were going to pass Bart's moderate total with little difficulty. This they did with seven wickets in hand, and play was continued until Pettigrew completed a forceful and well-played century. The nine Bart's bowlers tried had little success.

Scores: Metropolitan Police 193 for 4 wickets (J. Pettigrew 101 not out, W. Scarlett 41).

Table with 2 columns: Player Name and Runs/Wickets. Includes C. R. Morison, S. Littlepage, D. J. A. Brown, G. D. Wedd, R. C. Dolly, W. M. Capper, R. Mundy.

ST. BARTHOLOMEW'S HOSPITAL v. TIMES C.C.

Played at Ravensbourne on Wednesday, May 23rd. As the members of the Times had to get away early, stumps had to be drawn at 4.30, which entailed forcing the pace. Bart's batted first on a true wicket, and Kirkwood and Dolly lost no time in making 63 before Kirkwood left. The remaining batsmen came in with the idea of getting some runs or getting out, and in 1 hour 30 mins. before lunch 200 runs were added for the loss of 5 wickets. Dolly played a masterly innings, and not only hit the ball very hard, but gave no semblance of a chance, by placing the ball where there no fielders. It was a pity that he was not given the chance to complete a century, but under the circumstances Mundy could not do otherwise than declare.

The Times made a disastrous start, 5 wickets falling for 21 runs, due chiefly to the excellent and accurate bowling of Anderson, who

made his first appearance of the season. They were finally dismissed for 93, due chiefly to the continued accuracy of Anderson, whose figures speak for themselves:

Small table with 4 columns: o, m, r, w. Values: 12, 2, 5, 12, 7.

The fielding was good, with the exception of the mistaken idea (which has been prevalent for most of the season) that a half-volley should be thrown to the wicket-keeper.

Scores: Times C.C., 93. Bowling: J. D. Anderson, 7 for 12.

Table with 2 columns: Player Name and Runs/Wickets. Includes R. C. Dolly, R. M. Kirkwood, W. M. Maidlow, D. J. A. Brown, J. D. Wilson, C. R. Morison, C. G. Nicholson, S. Littlepage, J. D. Anderson, K. Mundy, J. B. Bamford, Extras.

ST. BARTHOLOMEW'S HOSPITAL v. M.C.C.

Played at Winchmore Hill on Thursday, May 31st. M.C.C. batted first on a good wicket, and found runs very hard to get against the accurate bowling of Mundy, Anderson, Cochrane and Dolly, and at lunch-time had only made 104 for 4 wickets. It was not until Stratfield joined Paxton that the runs started to come at all freely, and then in spite of still accurate bowling the score mounted so rapidly that the scorers had no spare time to change the telegraph between 170 and 210.

Bart's started disastrously, and 4 wickets were down for 14 runs. Then Mundy joined Morison and the complexion of the game changed for the better. After Morison left, Mundy continued to do more or less what he liked with the bowling, and his placing of the ball appeared to make the M.C.C. very short of fielders; but unfortunately after a 6 into the tennis courts to complete his 100 he was out, and after that there was no one left who looked like getting the extra 40 runs.

Scores: M.C.C., 243 (G. C. Stratfield 59, G. N. Paxton 41). Bowling: Mundy, 5 for 60; Cochrane, 3 for 50.

Table with 2 columns: Player Name and Runs/Wickets. Includes C. R. Morison, D. J. A. Brown, R. M. Kirkwood, G. D. Wedd, R. C. Dolly, W. M. Maidlow, R. Mundy, C. Nicholson, Childs-Clarke, S. Littlepage, J. D. Anderson, G. Akeroyd, J. C. Cochrane, Extras.

Bowling: Atkinson, 4 for 50.

ST. BARTHOLOMEW'S HOSPITAL v. BROADMOOR.

Played at Broadmoor on Saturday, June 2nd. After a delayed start, Broadmoor won the toss and batted on a very fast wicket. The Rev. Conolly batted well to make 47 out of 93, receiving in the process a good deal of bodily bruising from bumping balls!

Bart's won with 6 wickets to spare, and went on to make 185 for 8 wickets before stumps were drawn. Maidlow and Nicholson batted well against the fast bowling of Baker.

Scores: Broadmoor, 93. Bowling: Wedd, 3 for 32; Cochrane, 2 for 28; Nicholson, 2 for 5.

Table with 2 columns: Player Name and Runs/Wickets. Includes C. R. Morison, R. C. Dolly, G. D. Wedd, W. M. Maidlow, J. D. Wilson, W. M. Capper, J. D. Anderson, C. G. Nicholson, Rev. James, C. M. Dransfield, A. W. Little, J. C. Cochrane, Extras.

Bowling: C. Baker, 4 for 33.

ST. BARTHOLOMEW'S HOSPITAL v. ROYAL DENTAL AND CHIRING CROSS.

2nd Round Cup-tie. Played at Winchmore Hill on Thursday, June 7th, 1934. Winning the toss, Wedd decided that Bart's should bat first on a wicket which must have been the slowest yet this season. Kirkwood and Morison opened and found nothing very deadly in the bowling, although it was steady enough, but the chief difficulty for them seemed to be able to get the ball away on the unusually slow pitch and against keen fielding. When Kirkwood left, Wedd found the same difficulty, but the score mounted steadily to 95 for 2, when Morison was caught. Soon afterwards Wedd left, and then there followed a collapse, so that at lunch-time the score stood at 155 for 7 wickets. After lunch the remaining 3 wickets collected a very valuable 45 runs, of which Bamford played well to get 20 not out.

The wicket during the Bart's innings had been drying under a hot sun, and it was showing signs of becoming difficult, but fortunately for the R.D.H. and Charing Cross, a sharp shower before the innings began helped to take some of the shine off the new ball, and the wicket never became dangerous. Edmunds and Rees opened the innings confidently, but Anderson, securing two wickets in his second over, started a collapse, and when Berman was out, having made 37, the game was virtually over. Anderson, Cochrane and Wedd bowled well, which was fortunate, as both Mundy and Dolly were away. Bamford, behind the stumps, was up to county standard.

Scores: Royal Dental and Charing Cross, 73. Bowling: Cochrane, 3 for 20; Anderson, 3 for 24; Wedd, 2 for 25.

Table with 2 columns: Player Name and Runs/Wickets. Includes R. M. Kirkwood, B. Rees, C. R. Morison, G. D. Wedd, D. J. A. Brown, Kaufman, C. G. Nicholson, W. M. Capper, G. Wynnne, J. D. Anderson, C. M. Dransfield, J. B. Bamford, J. C. Cochrane, Extras.

ST. BARTHOLOMEW'S HOSPITAL v. PRESENT.

Played at Winchmore Hill on Saturday, June 9th. The Past were unfortunate in that a number of their players had to cry off at the last minute. They opened after winning the toss on a good wicket, but could only get 77 runs. Present contributed his part by running two runs which did not exist. Dr. Oldershaw and Dr. Bourne offered most resistance.

Bart's replied with 166 for 7 wickets, to which Kirkwood contributed a useful 61, and declared at this total at tea-time. In their second innings, apart from a stand between Gilbert and Capper, the Past fared little better and were all out for 114.

1st Innings. 2nd Innings.

Table with 2 columns: Player Name and Runs/Wickets. Includes Dr. Boney, Dr. Cochrane, Dr. Oldershaw, Mr. Capper, Mr. Gilbert, S. Littlepage, J. R. Jenkins, Mr. O'Connell, Dr. Parrish, Dr. Hodgkinson, Dr. Bourne, Dr. Spencer, Extras.

Bowling: Cochrane, 4 for 19; Dransfield, 2 for 16. Bowling: Nicholson, 2 for 20; Morison, 4 for 12; Dransfield, 2 for 5.

PRESENT.

Table with 2 columns: Player Name and Runs/Wickets. Includes Morison, Hodgkinson, Kirkwood, Maidlow, Parrish, Brown, J. D. Wilson, Mundy, Extras, Dransfield, Nicholson, Anderson, Akeroyd, Cochrane, Extras.

ST. BARTHOLOMEW'S HOSPITAL v. BEDFORDSHIRE C.C.C.

Played at Bedford on Wednesday, June 13th, 1934. This should have been a whole-day match, but as the Bart's cricketers in large numbers all seemed to be considering remote examinations very seriously, it was found necessary to communicate with Bedford at the last minute, who charitably decided that a half-day match was better than no match.

As it was, Bart's, with a skeleton team batted first on a good hard wicket, and would have fared very badly but for an excellent innings by Kirkwood, who carried his bat for 76 without giving a chance. He was supported to some extent by Dolly, Little and Berry. Tea was then taken, and Mundy, rightly deciding that a finish should be reached if possible, declared leaving Bedford just under two hours to get 156.

Mundy and Cochrane opened the bowling, and in spite of strenuous efforts from Bedford to go for the runs, they came slowly, partly because the short boundary was well guarded by fieldsmen. When Southgate joined Voly runs came more quickly, but at considerable risk against excellent bowling. For instance, Voly, in forcing the pace, gave three chances off successive balls, and had he not been caught the fourth time Bedford might easily have won. With 5 wickets down and 80 runs to get in 45 minutes Bedford gave up the struggle, and the result was a rather tame draw.

Scores: Bedfordshire C.C.C., 137 for 8. Bowling: R. Mundy and J. C. Cochrane took 3 wickets each.

Table with 2 columns: Player Name and Runs/Wickets. Includes C. R. Morison, Rawlins, R. M. Kirkwood, G. A. Akeroyd, D. J. A. Brown, Rawlins, R. C. Dolly, R. Mundy, W. M. Maidlow, A. W. Little, J. C. W. Rawlins, J. C. Cochrane, E. O. Evans, Extras.

Total (8 wks. dec.) 156.

ST. BARTHOLOMEW'S HOSPITAL v. HAMPSTEAD.

Played at Winchmore Hill on Saturday, June 16th. Bart's batted first on a perfect wicket, and after a disastrous start, losing both opening batsmen for 1 run, Morison and Dolly put on 70 before Dolly left. When Capper joined Morison the score started to mount quickly, but not nearly as quickly as when Mundy batted, scoring a very fine 61 runs in just over 40 minutes, including two 6's. Wedd declared at tea-time, leaving Hampstead 255 to get in two and a half hours—a not impossible task on a still perfect wicket.

With the exception of Atkinson, who hit hard for 44 runs, Hampstead played rather a negative game, and although they never really looked like being beaten, they looked still less like getting the runs, and stumps were drawn with 8 wickets down for 159 runs.

Scores: Hampstead 159 for 8 (Atkinson, 44). Bowling: Mundy, 2 for 27; Wedd, 2 for 33; Anderson, 2 for 44.

Table with 2 columns: Player Name and Runs/Wickets. Includes R. G. Gilbert, R. M. Kirkwood, Fraser, C. R. Morison, Frazer, R. C. Dolly, G. D. Wedd, W. M. Capper, R. Mundy, Mennin, C. G. Nicholson, J. D. Anderson, D. J. A. Brown, G. A. Akeroyd, Extras.

Total (9 wks. dec.) 271. Bowling: Partridge, 5 for 51.

RIFLE CLUB.

Shooting on the open range is now in full swing, three of the four stages of the Armitage Cup Competition having been shot. Unfortunately very few new members have turned up this season, but the keenness of the few who have has done much to discount the loss of the many.

The following are details of the Armitage Cup Competition to date:

1st Stage:

B. C. Nicholson	98
J. Dalziel	92
G. E. Underwood	91
G. H. Pickering	88
B. P. Armstrong	88
J. R. Davies	88
Grand total	548

Total scores:

1. The London	556
2. St. Mary's	548
Guy's	548
St. Bartholomew's	549
5. St. Thomas's	536

2nd Stage:

J. Dalziel	102
B. C. Nicholson	96
G. E. Underwood	96
H. Bevan-Jones	94
B. P. Armstrong	89
G. H. Pickering	80
Grand total	557

Total scores:

1. St. Mary's	1130
2. Guy's	1117
3. St. Bartholomew's	1105
4. The London	1100
5. St. Thomas's	1095

3rd Stage:

J. Dalziel	101
B. C. Nicholson	97
K. F. Stephens	97
B. P. Armstrong	96
J. E. Underwood	92
H. Bevan-Jones	91
Grand total	574

Total scores:

1. St. Mary's	1688
2. Guy's	1683
3. St. Bartholomew's	1679
4. The London	1661
5. St. Thomas's	1647

SWIMMING CLUB.

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

Played at Cambridge, Wednesday, May 30th.
Result: Swimming, 10-21; water polo, 4-8.
220 Yards: 1, I. C. Newbold (St. Bartholomew's); 2, P. Morrell-Thomas (Cambridge); 3, A. C. Kanaar (St. Bartholomew's). D. M. Kiralfy (Cambridge). Time, 2 min. 54½ sec.
100 Yards: 1, M. J. Clow (Cambridge); 2, N. Beale (Cambridge); 3, C. K. Vartan (St. Bartholomew's). P. Sultman (St. Bartholomew's). Time, 59½ sec.

Diving: 1, N. Beale (Cambridge); 2, D. G. Evans (St. Bartholomew's); 3, K. L. Armstrong (Cambridge). B. H. Goodrich (St. Bartholomew's).

Team Race: (60 yards per man) 1, Cambridge University Tadpoles; 2, St. Bartholomew's Hospital.

Teams:

St. Bartholomew's: C. K. Vartan, P. Sultman, A. C. Kanaar, B. M. Phillips, T. O. McKane, J. C. Newbold.
Cambridge: R. L. Armstrong, F. Colemay, R. Mitchell, A. Weltenscrott, R. O. Murray, K. Hijicati.
Time, 3 min. 35½ sec.

Water Polo.

During the first half the Hospital defended the deep end, and though the Tadpoles scored 6 goals, the Hospital were unlucky not to score on several occasions. During the second half the game became more even, the Hospital scoring 4 goals (Newbold 3, C. K. Vartan 1), while our opponents scored yet another 2.

Result: St. Bartholomew's, 4; Cambridge Tadpoles, 8.
Team.—C. M. Dransfield, D. H. Goodrich, G. S. Vartan, C. K. Vartan, T. O. McKane, J. C. Newbold, A. C. Kanaar.

1st Round Inter-Hospitals Water-polo.

ST. BARTHOLOMEW'S HOSPITAL v. ST. THOMAS'S HOSPITAL.

Played at Lambeth Baths on Friday, June 1st.
In the first round of the Inter-Hospitals Water-polo Bart's had a very decisive win over St. Thomas's, when they won by 8 goals to nil (J. C. Newbold 3, C. K. Vartan 2, T. O. McKane 2, R. J. C. Sutton 1).

Result: St. Bartholomew's, 8; St. Thomas's, 0.
Team.—G. S. Vartan, B. H. Goodrich, C. K. Vartan, R. J. C. Sutton, T. O. McKane, J. C. Newbold, B. M. Phillips.

ST. BARTHOLOMEW'S HOSPITAL v. HARROW SCHOOL.

Played at Harrow School on Saturday, June 2nd.
Result: St. Bartholomew's, 19; Harrow School, 16.
50 Yards: 1, R. S. Emerson (Harrow); 2, C. K. Vartan (St. Bartholomew's); 3, M. S. Wood (Harrow). G. S. Vartan (St. Bartholomew's). Time, 20½ sec.

100 Yards: 1, R. J. C. Sutton (St. Bartholomew's); 2, E. D. Rawes (Harrow); 3, A. G. Imber (Harrow). P. Saltman (St. Bartholomew's). Time, 64 sec.

Diving: J. H. Paterson (St. Bartholomew's); 2, R. S. Emerson (Harrow); 3, J. L. Elliott (Harrow). R. J. C. Sutton (St. Bartholomew's).

Relay Race:

St. Bartholomew's Hospital: C. K. Vartan, P. Saltman, R. N. Phillips, R. J. C. Sutton.
Harrow School: R. S. Emerson, A. G. Imber, M. S. Wood, E. D. Rawes.

Unfortunately, owing to the Club night being changed from Thursdays to Fridays later in the season, the match *versus* the Old Haberdashers' had to be scratched owing to their having another fixture.

Once again the Old Citizens had to scratch at the last minute owing to most of their team playing in a league polo match.
C. M. Dransfield, J. C. Newbold, R. J. C. Sutton and C. K. Vartan are to be congratulated on having been chosen to represent the United Hospitals' Water Polo Team during their recent successful Irish tour; unfortunately Sutton was unable to accompany the team.

TENNIS CLUB.

With increased practice the 1st and 2nd VI's have been more successful in some excellent matches. In the second round of the Cup-ties St. Bartholomew's beat St. Mary's by 9-0, although the match was closer than the score suggests. The 1st VI beat St. Thomas's by 6-3 and lost to Wentworth 2-7. In the Past v. Present match the latter were successful by 5-4.
The 2nd VI were beaten 5-4 by King's College Hospital, and lost to K.N.C. Greenwich by the same margin. In the second round of the Cup-ties they received a walk-over into the semi-final owing to St. Mary's scratching, and both the 1st and 2nd VI's will now meet St. Thomas's for a place in the final.

TIMES FOR ATTENDANCES IN THE OUT-PATIENTS' AND SPECIAL DEPARTMENTS.

	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
Medical Out-Patients	Dr. G. Bourne at 9 a.m.	Prof. Fraser and Dr. Hilton at 9 a.m.	Dr. Geoffrey Evans at 9 a.m.	Dr. F. G. Chandler at 9 a.m.	Prof. Fraser and Dr. Spencer at 9 a.m.	Dr. E. R. Cullinan at 9 a.m.
New cases: 9 a.m.						
Old cases: male, 10 a.m.; female, 10.30 a.m.						
Surgical Out-Patients	Prof. Gask at 9 a.m.	Mr. R. M. Vick at 9 a.m.	Mr. J. B. Hume at 9 a.m.	Mr. Paterson Ross at 9 a.m.	Mr. Rupert Corbett at 9 a.m.	Mr. Keynes at 9 a.m.
New cases: 9 a.m.						
Old cases: 10 a.m.						
Diseases of Women	Dr. Shaw (new cases at 9 a.m. only).	Cases referred from House Physicians and House Surgeons only at 10 a.m.	Dr. Donaldson at 1 p.m.†	Cases referred from House Physicians and House Surgeons only at 10 a.m.	—	Dr. Shaw at 9 a.m.
Ante-Natal Clinic	Dr. Shaw at 9 a.m.	—	—	Dr. Donaldson and Dr. Shaw at 12.30 p.m.	—	—
Orthopaedic Department	Mr. S. L. Higgs at 1 p.m.	—	—	Mr. R. C. Elmslie at 1 p.m.	—	—
Throat and Nose Department	Mr. Bedford Russell at 1 p.m.	Mr. Capps at 9 a.m.	—	Mr. Bedford Russell at 9 a.m.	Mr. Capps at 1 p.m.	—
Aural Department	Mr. S. R. Scott at 1 p.m.	Mr. T. H. Just at 9 a.m.	—	Mr. S. R. Scott at 9 a.m.	Mr. T. H. Just at 1 p.m.	—
Ophthalmic Department	Mr. Rupert Scott at 1 p.m.	Mr. Foster Moore at 1 p.m.	—	Mr. Rupert Scott at 1 p.m.	Mr. Foster Moore at 1 p.m.	—
Skin Department	—	Dr. Roxburgh at 9 a.m.	Dr. Roxburgh at 9 a.m.	—	Dr. Roxburgh at 9 a.m.	—
Psychological Department	—	—	—	—	Dr. Porter Phillips at 1.30 p.m.	—
*Electrical Department	Dr. Cumberbatch. Males at 2 p.m.	Dr. Cumberbatch. Females at 2 p.m.	—	Dr. Cumberbatch. Males at 2 p.m.	Dr. Cumberbatch. Females at 2 p.m.	—
*X-Ray Department	Dr. Stone at 9.30 a.m. Dr. Finzi at 1.30 p.m.	Dr. Stone at 9.30 a.m. Dr. Loughborough at 1.30 p.m.	Dr. Loughborough at 9.30 a.m.	Dr. Loughborough at 9.30 a.m. and 1.30 p.m.	Dr. Finzi at 9.30 a.m. and 1.30 p.m.	9.30 a.m.
*Exercises and Massage Department	Women, 9 a.m. Men and women, 1.30 p.m.	Men, 9 a.m. Men and women, 1.30 p.m.	Women, 9 a.m. till 1 p.m.	Men, 9 a.m. Men and women, 1.30 p.m.	Women, 9 a.m. Men and women, 1.30 p.m.	Men, 9 a.m. till 1 p.m.
Diseases of Children	Dr. Harris at 9 a.m.	Dr. Harris at 9 a.m.	Dr. Harris at 9 a.m.	Dr. Harris at 9 a.m.	Dr. Harris at 9 a.m.	Dr. Harris at 9 a.m.
Dental Department	Mr. Cowan at 9 a.m.	Mr. Coleman and Mr. Hardy at 9 a.m.	Mr. Hankey and Mr. Cambrook at 9 a.m.	Mr. Fairbank and Mr. Cowan at 9 a.m.	Mr. Hardy at 9 a.m.	Mr. Hankey and Mr. Cambrook at 9 a.m.
Tuberculosis Dispensary	—	12.30 p.m. to 2.30 p.m. Art. Pneumothorax Clinic, 2.30 p.m. 5 to 7 p.m.†	—	NEW CASES ONLY from 12.30 p.m.		
Venereal Department	Men, 5 to 7 p.m.	Women and children, 4 to 6 p.m.	—	Men, 12 to 2 p.m.	Women and children, 12 to 2 p.m.	—
Plastic Surgery	Sir Harold Gillies at 2 p.m.	—	—	—	—	—
Neurological Clinic	—	—	—	Dr. Hinds-Howell at 1.30 p.m.	—	—

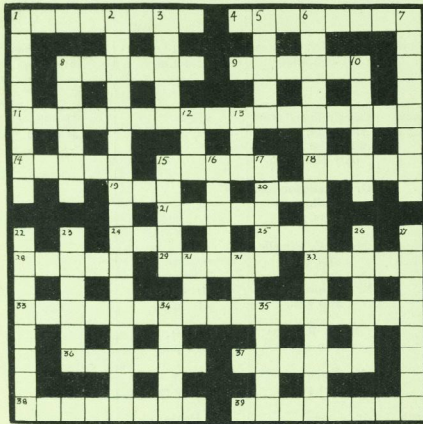
* Patients are not seen in these Departments unless recommended by the Medical Staff.

† These hours are intended for patients who cannot attend at mid-day.

‡ Patients with Doctor's letters only, or who have been previously examined by the Gynaecological House Surgeon.

CROSSWORD PUZZLE.

Solutions may be sent to the Editor. A de luxe copy of Round the Fountain will be given to the sender of the first correct solution opened after July 20th. Envelopes should be marked "Crossword". No correct solutions to last month's puzzle were received.



10. Doctors bury theirs.
12. Tail-less bird that gives the cry of another.
13. Another sort of bug.
15. Found unbroke in an American oak.
16. Child.
17. A conjoint tax that holds water.
22. Fair Italian's drug. Did she learn its use when a pupil?
23. Belloc says a fish hadn't enough of this to go into the water in the middle of it.
26. Obese and kindly tumour.
27. Arrangement of tubes.
30. Going part of 27 that fetched Mr. Swinley and makes puss +.
31. Tune that gives direction to a T in Scotland.
34. Schoolboys might often be said to be this of their clothes.
35. Done by most Romans whether musical or not.

SOLUTION TO LAST MONTH'S CROSSWORD PUZZLE.

Across.—1, Hind-gut. 4, Hip-bone. 8, Actinomycosis. 10, Int. 11, Cutaneous. 13, Pil. 14, Hurst. 15, Spurs. 17, Leads. 18, Boracic. 19, Borneol. 21, Adept. 22, Anode. 23, Odd's. 25, Oto. 26, Cobaltous. 29, Lag. 30, Stalagmometer. 33, Caseate. 34, Carotid.

Downs. 1, Hashish. 2, Gut. 3, Tenet. 4, Hecto. 5, Pus. 6, Embolus. 7, Omentum. 8, Arteriovenous. 11, Cathartic. 12, Selenious. 15, Spina. 16, Stone. 20, Colome. 21, Amoebic. 24, Sugared. 27, Blade. 28, Osmic. 31, A.B.A. 32, Tar.

CORRESPONDENCE.

TREATMENT OF BURNS.

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

DEAR SIR.—It may be of some interest to readers to hear of a very simple method which I use to apply tannic acid to burns. Messrs. Woolley & Sons, of Manchester, have prepared for me surgical lint impregnated with tannic acid and mercuric chloride in such proportions that when the lint is thoroughly saturated with water it contains a 2% solution of tannic acid and 1/2000 solution of mercuric chloride.

This affords a simple and convenient means of applying tannic acid to a burn, as suggested by Mr. Mitchiner, both as a first aid and as a permanent dressing.

I have successfully used this method in a number of cases, and the results have compared very favourably with those of others treated with fresh solution made from tablets.

Yours faithfully,

Hartford Hill, Northwich; A. H. BENNETT,
April 21st, 1934. M.R.C.S., L.R.C.P.

REVIEWS.

THE LAST OF THE TABOOS: MENTAL DISORDERS IN MODERN LIFE. By ISOBEL EMSLIE HUTTON, M.D. London: William Heinemann (Medical Books), Ltd. Pp. ix + 204. Price 6s.

To alter the attitude of the public towards mental disease is the frankly propagandist and valiant purpose of this necessarily superficial though comprehensive survey of insanity and its reaction to the social environment.

The aetiology, symptoms and treatment, as far as possible, are stated clearly, and in intelligently non-technical language. Sterilization, a short history of mental treatment and the legal aspect of insanity are among the subjects which are dealt with competently and briefly, and the concluding chapter is devoted to a constructively critical comparison of the present system of mental treatment, and what the author considers should be aimed at in the future, laying great stress on the importance of providing means to ensure early

1. Titillative test (*cf.* Ballads by Gilbertovitch).
4. Tall spectators are unpopular when.
8. The rope is brought to small account, one must agree.
9. Derivatives of the whole are found in a part.
11. Its general use might lessen the number of breach of promise actions.
14. Protuberance in 30.
15. Strange that so large a vessel should contain only a scrap of food.
18. He is wrathful, not relishing perhaps payment of the instalments due.
19. Singular expression of Cockney approval.
20. Narrow buddle.
21. Reduced allowance, lost by Antony's audience.
24. I'm too confused to explain.
25. Parasitic presentation.
28. Saul was born in one of these, and no mean one at that.
29. Typhoid or not typhoid, that is the question. I answer it.
32. All men have this Medical Author, said Sir Robert and others before him.
33. Rare tumour in 23.
36. Minced rabbits for Frenchmen with inflamed appendices and weak hearts.
37. Enid's lover, beheaded and in confusion, is a mere network of nerves.
38. Many persons have been burnt in these.
39. The Air Force with father at its head comes to a sudden end.

DOWN.

1. The vehicle has run backwards into the restaurant, destroying the front rooms and leaving nothing but a collection of small sticks.
2. Ill-effect (2 words) of Her Ladyship.
3. Nuclear anagram of a white rose city half as old as time.
5. Dorothy with a racquet in the wards.
6. Wan bug (2 words).
7. Cynical entomologist's comment on the first aeroplane.
8. Shakespeare's summons has gone sour.

and adequate treatment, especially for the hospital class of patient. This should be in the form of an out-patient clinic, a counterpart of the out-patient departments of the hospitals for organic diseases, which would enable the commencement of proper treatment early in the course of the disease, with a view either to preventing the eventual hospitalization of the patient, or at least to the shortening of that period.

This is but one of the several eminently practical suggestions and schemes put forward by the author, who, though at times her enthusiasm is apt to partake of the nature of fervour for the "cause", leading to minor exaggerations and inaccuracies, does not lose sight of the ultimate aim to be attained, namely, that of the removal of the stigma in the public mind attaching to the mental patient at present.

When, however, such a monumental task as the changing of the attitude of the British public is attempted, such enthusiasm is more than desirable; it is imperative. Yet one pen, no matter how full of vigour and fire, is not enough. It is necessary that others as capable and as experienced as Dr. Hutton should turn their attention to this subject of pressing importance—the alteration and improvement of the present system of mental treatment.

MIDWIFERY FOR NURSES. By H. RUSSELL ANDREWS, M.D., B.S., F.R.C.P., F.C.O.G., and VICTOR LACK, M.B., B.S., M.R.C.P., F.R.C.S., M.C.O.G. London: Arnold & Co., Ltd., 1934. Pp. viii + 268. Figs. 70. Price 6s.

Dr. Lack, in revising the new edition of this work, has paid particular attention to the questions of ante-natal care and puerperal infections, with a view to including a brief mention of recent work in both these fields. He has, however, succeeded in keeping the book as short and easily understood as is compatible with the requirements of the Examination of the Central Midwives Board.

The chapter at the end on Drugs in Common Use and Anaesthetics is a welcome addition, replacing, as it does, the Rules of the Central Midwives Board, which can easily be obtained separately. In other respects the text appears to be unaltered, with the exception of the chapter on infant feeding, which has been rewritten; and the book needs little further recommendation than the popularity which has already carried it through six editions, and made worth while its translation into three foreign languages.

SEX EFFICIENCY THROUGH EXERCISES. By M. H. VAN DE VELDE. William Heinemann, 1933.

The author has produced a book full of valuable information which can be usefully applied in spheres other than those which the title would suggest.

The chapter on Anatomy and Physiology is understandable to the uninitiated, and brings forward the salient points necessary for an explanation of the exercises, without undue details of possible interest but of impractical value; the part on the pelvic floor is particularly good.

The chapters describing the exercises are difficult to follow to the average person, and would, in fact, be a poor guide to one carrying out or teaching the exercises; such shortcomings are, however, more than compensated by the cinematograph pictures at the end of the book, which are clear, interesting and absolutely descriptive when taken either rapidly or, when learning the exercises, picture by picture.

The chapters on coition and prevention of gynecological conditions are brief, but serve as a guide to the reasons for and practical aims of the exercises. The illustrations are excellent and helpful.

SEX DIFFICULTIES IN THE MALE. By KENNETH M. WALKER, F.R.C.S. London: Jonathan Cape. Pp. 254. Price 5s.

This book first appeared as *Male Disorders of Sex* in 1930, and the present edition, bearing a new title, has been completely revised. Notably, the author has added a chapter on the subject of difficulties encountered in marriage, in which, in his own clear and concise style, he has dealt with a difficult subject in a manner satisfactory alike to the medical and non-medical reader. It is natural that in a work of this nature the question of intellectual as opposed to sexual adjustment should receive secondary consideration, and, while "it must be borne in mind that difficulties experienced on one plane react on difficulties encountered on another", it might be added

that a little knowledge of sexual relationships gleaned from an inadequate and perhaps inaccurate source is often the stumbling-block in cases of apparent failure from the sexual point of view.

It is to avoid such difficulties that a knowledge is essential of a kind such as Mr. Walker has provided in the easiest and most assimilable way. And he has introduced into the chapter already mentioned a reference to the observations of P. D. Guspensky and the idea of "different types" to explain what may, in the past, have been dismissed as cases of incompatibility. But how far this may be applicable in practice is difficult to say, for the subdivision which it implies is open to the criticism that, as in all attempts at classification in matters of this kind, the individual element is very difficult to assess. In theory it sounds easy; in practice it is liable to be too idealistic.

For the remainder, the subdivision of the book into two portions is retained, the second and much briefer dealing with the question of sterility. In that field, however, there is little progress to record in the time intervening between the appearance of the two editions of this book. In the first part, on the other hand, the author has re-written the sections on primary impotence, homosexuality and continence, and the illustration of his meaning by reference to specific cases clarifies a great many of the problems.

To those, then, who are daily being consulted on questions appertaining to sex difficulties the book should be of inestimable value, particularly in the light of its essentially practical teaching. To the lay reader also the book should be most useful, for it covers a wide field, with the use of a minimum number of medical terms, and in a manner very pleasant to read and certainly easy to understand.

We have also received the following:

PRACTICAL POINTS IN EYE SURGERY AND DRESSING. By HUGH E. JONES. Bale, Sons & Danielsson. Price 25s. 6d.

BERKSHIRE ROYAL INFIRMARY REPORTS.

AIDS TO ELEMENTARY HYGIENE. By EVELYN PEARCE. Faber & Faber. Price 3s.

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

CHRISTOPHERSON, J. B., C.B.E., M.D., F.R.C.P. (and BROADBENT, MARJORIE, M.R.C.S.). Ephedrine and Pseudo-Ephedrine in Asthma and Emuresis. *British Medical Journal*, June 2nd, 1934.

DALE, SIR HENRY, C.B.E., M.D., F.R.C.P., F.R.S. Chemical Transmission of the Effects of Nerve Impulses. *British Medical Journal*, May 12th, 1934.

EVANS, COURTENAY, M.D., M.R.C.P. See SPARKS and EVANS.

HARRIE, H. ELWIN, M.A., M.B., F.R.C.S. Looking Back. *Bristol Medico-Chirurgical Journal*, Spring, 1934.

HINDS HOWELL, C. M., M.D., F.R.C.P. The Effects of Common Salt in Addison's Disease: Record of a Case. *Lancet*, May 26th, 1934.

KEYNES, GEOFFREY, M.A., M.D., F.R.C.S. Avertin Narcosis in Operations for Toxic Goitre. *British Medical Journal*, May 12th, 1934.

PAPADOPOULOS, S. G., M.B., B.S. A Case of Double Intussusception. *Lancet*, June 2nd, 1934.

SMYTH, F. G. A., Major I.M.S. Blood Tellurite Agar as a Selective Medium for *Corynebacterium diphtheriae*. *Journal Royal Army Medical Corps*, June, 1934.

SPARKS, J. V., M.R.C.S., D.M.R.E., and EVANS, COURTENAY, M.D., M.R.C.P. Radiography of Calcification in Cardiac Valves during Life. *British Medical Journal*, June 9th, 1934.

THROWER, W. R., M.D., M.R.C.P. The Significance of Precordial Pain. *Clinical Journal*, June, 1934.

WEBER, F. PARRIS, M.D., F.R.C.P. (and SCHWARZ, E., M.D.). Cyst of Pleura outside the Parietal Pleura. *British Medical Journal*, May 12th, 1934.

RECENT ADDITIONS TO LIBRARY.

BACTERIOLOGY.

WHITBY: *Medical Bacteriology*.

GYNÆCOLOGY.

YOUNG: *Text-book of Gynecology*. Third edition.

HISTORY OF MEDICINE.

BETT: *A Short History of Some Common Diseases*.

MEDICINE.

BEAUMONT: *Medicine*. Second edition (2 copies).
VAUGHAN: *The Anæmias*.
Medical Annual 1934.

MIDWIFERY.

The Queen Charlotte's *Text-Book of Obstetrics*. Third edition.

OPHTHALMOLOGY.

PARSONS: *Diseases of the Eye*. Seventh edition.

PATHOLOGY.

HADFIELD and GARROD: *Recent Advances in Pathology*. Second edition.
PANTON and MARRACK: *Clinical Pathology*. Third edition (2 copies).

PHARMACOLOGY.

CUSHNY: *Text-book of Pharmacology and Therapeutics*. Tenth edition (2 copies).

PHYSIOLOGY.

WRIGHT: *Applied Physiology*. Fifth edition (2 copies).

SURGERY.

SOUTTAR: *The Art of Surgery*. Second edition.EXAMINATIONS, ETC.
University of Cambridge.Third Examination for Medical and Surgical Degrees,
Easter Term, 1934.

Part I.—Culshaw, F. H., Dale, R. H., Daniel, T. M., Harris, E. E., Hulbert, N. G., Livingstone, F. D. M., Martin, K. W., Pope, A. R., Sen, S. K.

Part II.—Benison, R. L., Blair, A. T., Hindley, G. T., Hulbert, N. G., Innes, A., Levick, R. E. K., Martin, C. J., Richards, W. F., Saunders, S. B. H., Williamson, H. W.

University of London.

Third (M.B., B.S.) Examination for Medical Degrees, May, 1934.

Honours.—* Bintlcliffe, E. W., † Jones, E. G.

* Distinguished in Medicine and Surgery.
† Distinguished in Medicine.

Pass.—Chivers, J. A., Danino, E. A., Dean, D. M., Gale, H. E. D., Hayward, S. T., Hugh, H. C., Lee, H. B., Royle, H., Selwyn, H. L., Shackman, R., Telfer, W. P. M.

Supplementary Pass List.

Group I.—Blomfield, D. M., Edward, D. G. ff., Iliff, A. D., Jones, F. Avery, Staunton, H. W. G.

Group II.—Carpenter, R., Clarke, R. F., Houghton, A. W. J., Kingdon, J. R., Latter, K. A., Purnell, R. H., Reavell, D. C., Roden, A. T., Smith, M. C. L., Stephens, K. F.

CHANGES OF ADDRESS.

CUMBERLIDGE, W. L., "Eastfield", Stanley Road, Leicester. (Tel. 77400.)

DALE, W. C., c/o R. H. Brodie, Esq., "Barngleish", Rowley Green Road, Arkley, Barnet, Herts.

HEINTSCHEL, C. C., 7, Dudley Court, Upper Berkeley Street, W. 1.
HOGG, W., Grimsby Corporation Hospital, Scaurtho, Grimsby, Lincs.
WAY, A. O., Little Dene, Shepherd's Lane, Compton, Hants.

APPOINTMENTS.

CLEGG, H. A., M.B.(Cantab.), M.R.C.P., appointed Deputy Editor, *British Medical Journal*.

HOGG, W., M.B.(Lond.), D.P.H., appointed Resident Medical Officer to the Grimsby Corporation Hospital.

TAIT, C. D. V., M.B., B.S.(Lond.), D.O.M.S., appointed Hon. Consulting Ophthalmic Surgeon, Saverlake Hospital.

WILLOUGHBY, H. M., M.R.C.S., L.R.C.P., D.P.H., D.T.M.H., appointed Extra Physician on the Honorary Staff of Tilbury Hospital (Seaman's Hospital Society).

BIRTHS.

BOURNE.—On June 15th, 1934, at Abbotsleigh, Rolle Road, Exmouth, to Joyce, wife of William A. Bourne—a daughter.

BUCKLEY.—On May 22nd, 1934, at Shearwood Road Nursing Home, Sheffield, to Nancy, wife of W. Buckley, of Worksop, Notts—a son.

HENSMAN.—On June 12th, 1934, at 29, Devonshire Place, W. 1, to Catharine (née Kirkpatrick), wife of Dr. Stuart Hensman, of 2, Buckingham Street, Buckingham Gate, S.W. 1—a son.

HOLMES.—On June 17th, 1934, at a nursing home, to Barbara (née Hopkins), wife of Eric Holmes, M.A., M.D., Cambridge—a son.

MCNAIR.—On June 20th, 1934, at 27, Welbeck Street, to Grace (née Buist), wife of Arthur J. McNair—a daughter.

REYNOLDS.—On June 3rd, 1934, at 2, Highfield Crescent, Southampton, to Evelyn Constance, wife of Dr. John B. A. Reynolds—a daughter (Elizabeth).

MARRIAGES.

BURROWS—JACKSON.—On June 12th, 1934, at Christ Church, Heaton, by the Revs. N. F. Tripp, M.A., M.C., and P. B. Jackson, M.A., L.Th., William Ralph, son of Mr. and Mrs. Alfred Burrows, Quorne, Leicestershire, to Nancy, the only daughter of Mr. and Mrs. Harry Jackson, of 183, Chorley New Road, Bolton.

MCMENEMEY—INKSTER.—On June 10th, 1934, at King's College Chapel, Aberdeen, William Henry McMenemey, D.M., M.R.C.P., only son of Mr. and Mrs. William McMenemey, of Prenton Hill, Birkenhead, to Ruby, youngest daughter of the late James Inkster, Aberdeen.

WILLIAMSON—MADDEN.—On June 9th, 1934, at All Saint's, Hove, James Charles Frederick Lloyd Williamson, F.R.C.S., only son of Dr. and Mrs. C. F. Williamson, of "Clerklands", Horley, to Helen Francis, third daughter of Capt. and Mrs. C. H. Madden, of "Sussex Lodge", Shoreham.

DEATHS.

JAMES.—On June 18th, 1934, suddenly, Arthur William James, M.D., of 69, Gloucester Terrace, W. 2.

NEWTON-DAVIS.—On June 19th, 1934, suddenly, at St. Bartholomew's Hospital, where he was a student, John Vaisey, only child of Lt.-Col. C. Newton-Davis, M.C., I.M.S., aged 19.

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: National 4444.

St. Bartholomew's Hospital



JOURNAL.

"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

Vol. XLI.—No. 11.]

AUGUST 1ST, 1934

PRICE NINEPENCE.

CALENDAR.

Fri., Aug. 3.	—Lord Horder and Sir Charles Gordon-Watson on duty.
Tues., ,, 7.	—Dr. Hinds Howell and Mr. Harold Wilson on duty.
Fri., ,, 10.	—Dr. Gow and Mr. Girling Ball on duty.
Tues., ,, 14.	—Dr. Graham and Mr. Roberts on duty.
Fri., ,, 17.	—Prof. Fraser and Prof. Gask on duty.
Mon., ,, 20.	—Last day for receiving matter for the September issue of the Journal.
Tues., ,, 21.	—Lord Horder and Sir Charles Gordon-Watson on duty.
Fri., ,, 24.	—Dr. Hinds Howell and Mr. Harold Wilson on duty.
Tues., ,, 28.	—Dr. Gow and Mr. Girling Ball on duty.
Fri., ,, 31.	—Dr. Graham and Mr. Roberts on duty.

EDITORIAL.



HAOS is come again with the holiday transmutation of the wards. What may be a time of diversion and enjoyment to the carefree patient and student, brings a whole world of restless cares to those beset with the trials of organization.

In one case this year, Surgery accommodates Medicine in the New Block. The prey of the Scalpel makes way for the subjects of the Stethoscope. P.D.U.'s and colostomies give place to P.A.'s and diabetics, splints and dressings to sputum-mugs and diet-sheets. The Staff are therefore to be congratulated on the composure with which they meet the situation.

Happy are they that have succeeded in arranging their holidays so as to avoid a part at least of this time—the dresser with his greedily snatched, and as grudgingly given fortnight, with the inevitable "extra couple of days" and the chief with his luxurious month or more. *Tempus est ludendi* and the results are similar on the return—"pigmentation plus" and that air of mild dejection that the proverb promises to the many.

* * *

At the Royal College of Surgeons Sir Holburt Waring was re-elected President by the Council.

Mr. H. J. Seddon and Mr. G. C. Knight were appointed Hunterian Professors; Mr. R. W. Raven was appointed an Erasmus Wilson Lecturer.

R. J. Brocklehurst, M.A., D.M., Professor of Physiology at Bristol University, has been appointed Dean of the Medical Faculty.

* * *

The following St. Bartholomew's men have been elected to serve on the Council of the British Medical Association for the year 1934-35, viz.: W. McAdam Eccles, P. L. Giuseppi, Lewis G. Glover, E. W. G. Masterman, F. A. Roper, W. E. Waterfield, W. G. Willoughby.

* * *

Mr. E. W. G. Masterman, in his Presidential Address to the Metropolitan Counties Branch of the B.M.A., dealt with the Council General Hospitals of London, viewed from within in relation to the medical profession. We cannot, in the small space at our disposal, do any justice to the address, but it is reported fully in the *British Medical Journal* (Supplement), June 30th, 1934, p. 333. We recommend it, however, to everyone for its clear presentation of the many problems involved. Special emphasis is laid on the value of the L.C.C. hospitals as potential training-grounds for the student and young practitioner.

The address concludes: "Briefly, I would have the medical profession, in London at least, to realize that the council hospitals are no hostile rivals of our old voluntary hospitals, but necessary and working allies; that the new service, now so unified, is becoming rapidly worthy of our great city, and destined to be a growing boon to the poor of London; and lastly, that the service presents both to the young practitioner and to the would-be nurse openings for a career and opportunities for education and service well worthy of their consideration."

A Central Committee is to be set up to deal with the affairs of the London voluntary hospitals in order that the present duplication of activity may be avoided.

Agreement has now been secured, following conferences between representatives of the London Voluntary Hospitals Committee and the London Regional Committee of the British Hospitals Association.

* * *

A. W. Franklin and A. E. Robb Smith have been selected for the Dorothy Temple Cross Research Fellowships in Tuberculosis for 1935, for America and Europe respectively.

* * *

R. J. Sutton has been selected to represent England at the British Empire Games in the 100 yards swimming race. He was also chosen to captain the water-polo team against Hungary and to play against Wales and Ireland. The banner of the Cross of St. George is to be carried by him at the parade of the Nations.

C. P. Reilly will represent Australia in the 440 yards Hurdles. In an exhibition race on July 28th he beat the English representative by a yard.

* * *

We have read in the lay press that R. Bettington, amateur golf champion of Australia, is beginning to take his golf "more seriously" with a view to higher honours.

* * *

X-RAY DEPARTMENT.

We have been asked to make the following corrections to the Time-table published in our last issue:

DIAGNOSTIC SECTION.—At 9.30 a.m.: Monday, Dr. Loughborough; Tuesday, Dr. Finzi and Dr. Sparks; Wednesday, Dr. Stone; Thursday, Dr. Loughborough; Friday, Dr. Sparks; Saturday, Dr. Sparks.

At 1.30 p.m.: Monday, Dr. Sparks; Tuesday, Dr. Stone; Thursday, Dr. Stone; Friday, Dr. Loughborough.

THERAPY SECTION.—At 9.30 a.m.: Monday, Chief Assistant; Tuesday, Chief Assistant; Wednesday, Dr. Levitt; Thursday, Chief Assistant; Friday, Dr. Levitt; Saturday, Chief Assistant.

At 1.30 p.m.: Monday, Dr. Finzi and Dr. Levitt; Tuesday, Dr. Levitt; Thursday, Dr. Levitt; Friday, Dr. Finzi.

* * *

THE ST. BARTHOLOMEW'S HOSPITAL GOLFING SOCIETY.

The St. Bartholomew's Hospital Golfing Society held their Seventh Summer Meeting at Beaconsfield on Wednesday, June 20th. The meeting was a most enjoyable one, and the course played well and, in spite of the drought, the greens were excellent. Twenty-four members took part in the competitions and the majority stayed to supper. The hospitality of the Club was much appreciated, thanks to the Secretary and Steward of the Club.

The results were as follows:

GORDON-WATSON CUP.

Winner: E. F. S. Gordon (3 up). Runner-up: W. A. Barnes (1 down).

Best "Last 9 Holes": 1, E. F. S. Gordon (4 up); 2, B. Rait Smith (1 up); 3, R. S. Corbett (all square).

Seated Holes: B. Rait Smith (1 up); T. H. N. Whitehurst (1 up).

FOURSOMES.

J. G. Milner and J. W. D. Buttery (1 up); W. A. Bellamy and R. S. Corbett (1 up); E. M. Darmady and B. Rait Smith (3 down).

Best "First 9 Holes": J. G. Milner and J. W. D. Buttery (2 up); A. C. Roxburgh and J. H. T. Davies (all square); W. A. Bellamy and R. S. Corbett (all square).

Seated holes: J. G. Milner and J. W. D. Buttery (2 up); Bedford Russell and F. L. Hopwood (1 down); W. A. Bellamy and R. S. Corbett (1 down); E. P. S. Gordon and R. Coyte (1 down).

Thanks to Lord Riddell and Sir Milsom Rees, arrangements have been made for the Society to play the Autumn Meeting at Walton Heath on **Tuesday, October 2nd, 1934.**

* * *

A CONTRIBUTION TO PATHOLOGY.

The street medicine vendor was addressing an admiring audience:

"I don't believe for one moment," he said, "that any person standing here, unless he is a medical man, can point out to me where the *tooberclar* vein lies in his body—Yes!" he thundered, "the *tooberclar* vein."

He then produced an embellished diagram of the sympathetic system and showed us where the vessel descended from the region of the left axilla to the mediastinum.

"Sunbathing," he continued, "is one of the worst things you can do to yourself, as all doctors know. Just for one hour it is all right, but only for an hour; when you go beyond this the rays begin to tell on the body, and the *tooberclar* vein gets stopped, and then blocked up altogether. Then the blood flow is stopped and *tooberclerosis* sets in."

At this point I passed on, marvelling at the extent of my ignorance of a structure of such importance.

Ultra-violet radiation may be inadvisable in phthisis, but one had not heard before this attractive theory of its aetiology.

CROSSWORD SOLUTION.

ACROSS.—1, Babinski. 4, Prostate. 8, Accord. 9, Purine. 11, Electrocardiogram. 14, Inion. 15, Aorta. 18, Hiner. 19, Ear. 20, Tye. 21, Ratio. 24, Oto. 25, Loa. 28, Iarsi. 29, Widal. 32, Price. 33, Oligodendrogloma. 36, Spinal. 37, Retina. 38, Effigies. 39, Paraffin.

DOWN.—1, Bacteria. 2, Nicotine poisoning. 3, Karyo. 5, Round. 6, Spirocheta pallida. 7, Ephemera. 8, Acetic. 10, Errors. 12, Coe. 13, Rot. 15, Arrow. 16, Rated. 17, Atoll. 22, Atropine. 23, Brains. 26, Lipoma. 27, Venation. 30, Ion. 31, Air. 34, Enate. 35, Opeua.

Again no correct solutions were received. Dr. C. F. Hatfield has been awarded the prize, having only three mistakes in the two puzzles.

Owing to lack of space there is no Crossword this month, but it is hoped that another will appear in September.

OBITUARY.

MR. WILLIAM FOSTER CROSS.



WILLIAM FOSTER CROSS, M.R.C.S.(Eng.), L.R.C.P.(Lond.), Consulting Anaesthetist to St. Bartholomew's Hospital, who died at his residence, Clay Point, Flushing, Falmouth, on July 14th, was the third son of the late Mr. William Henry Cross, B.A., J.P., who held the post of Clerk to the Governors from 1866 to 1905.

William Foster Cross was born within the precincts of St. Bartholomew's, and lived the greater part of his life there. As a boy and as a student he lived in the Clerk's House with his father. During the exceptionally long period in which he held the post of Resident Anaesthetist he was, of course, still within the Hospital walls. After joining the Visiting Staff he continued to give the major part of his working time to the service of his Hospital. He had the old-fashioned Bart's tradition in his bones that the Hospital has the first claim on its Staff. When I first knew him he was already Junior Resident Anaesthetist. He had the makings of a very competent general physician, but he made himself a superlative anaesthetist. Within a brief period his reputation was so far established that he was doing a considerable private practice. At the time of his election to the Visiting Staff his position was already assured. For the remainder of his professional life he devoted himself quietly and efficiently to his Hospital and his practice. His reputation rested almost entirely on personal contacts. He wrote nothing, and away from the Hospital he talked little of anaesthetics.

Cross was the third and possibly the greatest of the three great Bart's chloroformists. He followed in the tradition and practice of Mills and Gill, and worked miracles with a drop-bottle and a bit of lint. With his patients he was quietly cheerful, encouraging and competent. During operations he was always vigilant and collected, refusing to be "rattled". He had an almost uncanny power of knowing exactly what the patient's condition was, and the great gift of absolutely level anaesthesia. His patients were seldom sick after operation, and could be forgotten by the surgeon during operation.

As a colleague he was admirable. He had a great capacity for smoothing out the small tangles and annoyances which are bound to occur between the interlocked departments of surgery and anaesthetics. As an anaesthetist he was on the conservative wing. He was not fond of new methods and made little use of them, preferring to stay in the ways by which he got such

admirable results. As a companion he endeared himself to his many friends.

During the years of his retirement in Cornwall his main interests were his garden, and the persistent exploration of the county in his car. He was never a robust man, but he enjoyed on the whole a better level of health after retirement than in London.

Reputations often die almost more quickly than their owners. W. F. Cross should be remembered as one of the founders of the St. Bartholomew's School of Anaesthetics.

C. E. W.

THE TREATMENT OF STERILITY IN THE MALE.*



THE fact that I have been asked to take part in a discussion on sterility is in itself a sign that times have changed, and that the importance of examining the husband in cases of childless marriage is now fully recognized. Although we are more concerned to-day with the question of treatment, it is impossible to deal with this satisfactorily without a few preliminary remarks on the question of diagnosis, for it is on this that the treatment we adopt must depend.

Briefly stated it may be said that the surgeon who undertakes to investigate the fertility of any male must be prepared to answer the following questions: Is the semen deposited properly within the female passages? Does it contain a sufficient number of healthy, active spermatozoa? Are the secretions of the accessory sexual glands normal and conducive to the life and well-being of the spermatozoa?

The first question is, as a rule, easily answered, and need not be discussed. It is, of course, a well-known fact that a woman may conceive even although the semen is deposited at the entrance to the vagina, but other things being equal, impregnation is more likely to occur when the semen is ejaculated on to the cervix. For this reason the rectification of sexual disabilities in the male, such as premature ejaculation and weakness in desire, with, as a consequence, infrequent coitus, may form part of the treatment of a childless marriage.

The answers to the questions whether the semen contains a sufficient quantity of healthy, vigorous spermatozoa and whether the secretions of the accessory sexual glands are normal are obtained from the examination of a condom specimen. The fact that he can examine and estimate the number of cells present in an ejaculation gives the andrologist a great advantage over the gynaecologist. Whereas the latter can only presume that ova are being formed and discharged

* A lecture in the Post-Graduate Course given in St. Bartholomew's Hospital.

when he finds an apparently normal ovary, the genitourinary surgeon can state with absolute certainty whether the male gamete is present in sufficient numbers for impregnation. He is, indeed, in a position to express an opinion as to the degree of fertility that exists, for this will depend to a great extent on the number of healthy spermatozoa deposited in the female passages at each intercourse. Dr. Macombie and M. E. Saunders have stated, as a result of their experience, that if there be less than sixty million spermatozoa per c.c. of semen, conception is unlikely to occur. My own feeling is that this statement must not be taken too absolutely, for in my practice I have encountered husbands suffering from severer degrees of oligozoospermia than this who have succeeded in impregnating their wives. This, however, does not alter the fact that conception is less likely to occur when a low spermatozoan count is obtained. I agree also with these investigators' statement that generally speaking the larger the size of the testes, the greater will be the fertility. Low spermatozoan counts are most frequently found in patients with small testicles.

The question whether the secretions of the accessory sexual glands are favourable to the life and well-being of the spermatozoa can be answered with less certainty, owing to the fact that the rôle of the accessory sexual glands in reproduction is imperfectly understood. Nevertheless, the discovery of pus-cells in these secretions is of importance, for pyospermia almost always implies a state of lowered fertility. Not infrequently it is associated with necrozoospermia.

On looking through my case-records I find that the commonest causes of sterility in the male are azoospermia or oligozoospermia, and it is, therefore, with the treatment of these conditions that we are chiefly concerned to-day. It is obvious that azoospermia or complete absence of spermatozoa from the semen may result from one of two causes—the existence of an obstruction in the genital tract that prevents the escape of spermatozoa into the outer world, or failure on the part of the testes to secrete them. The commonest cause of the former is a previous attack of gonorrhœa associated with bilateral epididymitis. Careful palpation of the lower pole of the epididymis will, in these cases, generally reveal the existence of an indurated area. It was in the hope of remedying this occlusion of the epididymal canal that Martin, of Philadelphia, many years ago introduced the operation of vaso-epididymostomy. Owing, however, to the smallness of the ducts involved and the inevitable cicatrization that followed operation, his attempt to short-circuit the obstruction in the epididymis rarely, if ever, succeeded, and most surgeons have now abandoned the

operation of vaso-epididymostomy as impracticable. Recently, however, F. R. Hagner has published far more favourable results than have previously been claimed, and has encouraged others to give the method a further trial. Hagner's technique differs very little from that generally adopted, but he lays emphasis on the necessity of examining microscopically the fluid obtained from the epididymis at the site of implantation of the vas in order to make certain that spermatozoa are present in that situation. He also recommends the use of fine silver wire as a suturing material. Employing this technique, he states that 19 out of 31 patients were cured, the proof of the cure being that they became fathers. These figures are somewhat astonishing, and neither I nor any other investigator have yet been able to rival his performance.

In my practice azoospermia due to absence of spermatogenesis has proved of more frequent occurrence than azoospermia resulting from blockage. It has, indeed, surprised me how often one discovers this condition in men whom a cursory examination would lead one to pass as fertile males.

The causes of azoospermia are varied, for it must be remembered that the spermatogenic function of the testicle is one of the most delicately poised of all glandular mechanisms. Indeed, there are few pathological changes that can take place either in the testicle or elsewhere in the body that do not affect it. It would be possible to occupy the whole of the time at my disposal in discussing the reaction of spermatogenesis to infective processes, to toxæmias, to radiations, to endocrine disturbances and to diet. In my opinion, practically every disturbance of the general efficiency of the body may have repercussions on spermatogenesis, and the fact that menagerie animals, even when kept under the best possible conditions, generally become sterile, supports this view. The treatment of spermatogenesis, therefore, resolves itself into a raising of the general level of health, the elimination of any depressing factor elsewhere in the body, and in attention to a great many details which at first sight might seem unconnected with the act of reproduction. In the stockyard, the sterile animal is put out to grass in the hope that increased health will revive the ability to reproduce. My own feeling is that if to sedentary humanity the same treatment could be meted out, there would be an immediate rise in the birth-rate.

There are two other possible lines of treatment, both based on the idea of providing a stimulus to the testicle. The gonads are more directly under the influence of the pituitary than of any other gland, and the administration of anterior pituitary in cases of spermatogenic deficiency is a logical step. Moreover, the work of

Paul, Osborne, Evans, Bishop and many others has clearly shown that fertility is markedly affected by diet. Whether we believe in the existence of vitamin E or not, it is an undoubted fact that when rats are kept on a deficient diet, degenerative changes may be seen in the testes. With this in view, I am giving to husbands suffering from aspermatogenesis wheat germ oil, in the hope that a liberal supply of vitamin E may have a good effect.

But, as in most problems in medicine, the more one studies the riddle of sterility, the more complicated does it become. Where a single factor was once believed to exist, several factors are now found. Some of these have already been noted, but there is one that has not yet been mentioned, namely, the factor of heredity. Just as there are infertile breeds in the stockyard, so are there infertile families in human society, and on inquiring into the family history of childless husbands, one frequently finds that they themselves are only children, and that their aunts, uncles and cousins are few. Little is it to be wondered at that with so many blanks in our knowledge, and with so many factors to be considered, the medical man who is called upon to treat sterility in the male should be deeply conscious of his helplessness.

KENNETH WALKER.

THE TREATMENT OF STERILITY IN WOMEN.*

IT is impossible, within the limits of this lecture, to discuss the treatment of sterility in women in detail, and only a few methods will be mentioned.

The fertility rate in this country is difficult to determine at the present time owing to the rapidly spreading use of contraceptive measures, but there is no reason to suppose that the sterility rate has increased since Matthews Duncan carried out an extensive investigation of the subject at the end of last century. The figures obtained were as follows:

Percentage of cases failing to bear a child within two years of marriage: Aged 20-30, 17%; aged 30-40, 48%; aged 40-50, 90%.

These figures do not give the true sterility rate, as conception is fairly common after two years of married life, but they indicate the rapid increase in the sterility rate as age progresses.

In a normal menstrual cycle of 28 days, ovulation

* A lecture in the Post-Graduate Course given in St. Bartholomew's Hospital.

has been proved conclusively to occur between the twelfth and seventeenth days, and there is no scientific evidence in the human being that dependent ovulation occurs as a result of coitus. If this is the case, then the period of high probability as regards fertilization of the ovum rises rapidly as the time of ovulation approaches, and falls rapidly as menstruation approaches. If dependant ovulation does occur in woman, it will do so after a coitus which occurs before the period in which independent ovulation normally takes place.

In the investigation of sterility it is probably justifiable to refrain from detailed examination of the woman by tubal insufflation, etc., until the patient of between 20 and 30 years has been living a normal married life for three years, and for two years if she is between 30 and 40 years old. In all cases the husband should be examined before detailed examination of his partner is carried out.

The following classification is of some value in the elucidation of the various causes of sterility.

Negative history: Positive findings.—Congenital hypoplasia causing the various maldevelopments of the uterus, appendages and vagina. Sometimes associated with extreme intrinsic dysmenorrhœa and scanty menses.

Positive history: Positive findings.—Inflammatory causes; fibro-adenomata; pelvic endometriosis, etc.

Negative history: Negative findings.—Incompatibility or sterile by immunity, which sometimes appears to be an acquired condition.

A large number of patients who complain of sterility have no palpable abnormality in the pelvic organs, and in these cases it is necessary to test for the patency of the Fallopian tubes. This can be done either by insufflation of the uterus and tubes with air or other gas, or by the injection of lipiodol into the uterus followed by an X-ray photograph of the pelvic organs. Rubin, after many years' experience with the insufflation method, has found that in 33% of cases of sterility due to the female there is tubal occlusion. The test is easily carried out, but an anæsthetic is necessary, and the apparatus must be tested for air leaks before it is used; at no time must a pressure of over 200 mm. of mercury be exceeded in the cavity of the uterus and Fallopian tubes. The patency of the tubes is determined by the subsiding pressure in the cylinder used, and by listening *per abdomen* to the hissing noise produced by the passage of gas through the Fallopian tubes into the peritoneal cavity. An X-ray of the abdomen will also show a pneumoperitoneum if gas has passed through one or both Fallopian tubes. Pregnancy occurs soon after this treatment in some cases, possibly owing to the fact that the gas under pressure in the tube has

unstuck the plicæ of the mucous membrane which were adherent and bound together. It is possible also for the gas pressure to blow out a plug of mucus which is inspissated, thus causing tubal occlusion. Rubin believes that spasm at the utero-tubal junction does occur, and that by the use of tubal insufflation this can be overcome.

The injection of lipiodol under pressure into the uterus followed by an X-ray has some advantages over the insufflation method. The X-ray photograph

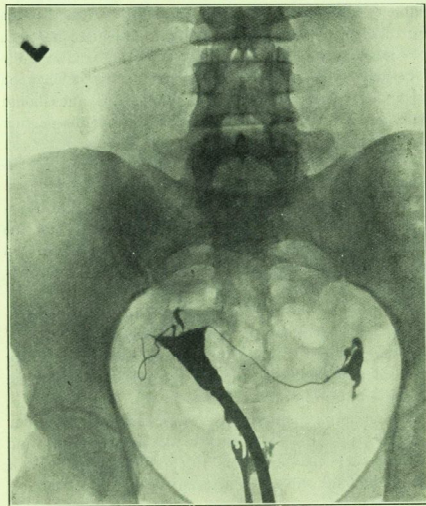


FIG. 1.—X-RAY PHOTOGRAPH OF UTERUS AND FALLOPIAN TUBES AFTER INJECTION OF LIPIODOL. BOTH FALLOPIAN TUBES HAVE FILLED NORMALLY.

obtained shows exactly where the tube is blocked, which is of great value in deciding whether the operation of salpingostomy is justifiable or not (Fig. 2). The iodine content of the lipiodol may be beneficial in cases of mild catarrhal salpingitis which have left the tube in an abnormal condition, but neither insufflation nor lipiodol injection should be undertaken if there is any evidence of a recent cervical or tubal infection.

The operation of salpingostomy may be undertaken in selected cases, but as conception occurs in only about 17% of cases following this operation, it should be performed only on patients who are willing to undergo any treatment in order to obtain a child.

Retroversion may be a cause of sterility, as there is

evidence for saying that a retroverted uterus can cause tubal occlusion, which is cured by anteversion. The cervix of a retroverted uterus is directed forwards and downwards, and may come into contact with the anterior vaginal wall in the region of the anterior fornix; the spermatic fluid normally collects in the posterior fornix and, in such cases, may not reach the cervical canal in appropriate quantity. In some cases of retroversion of the uterus the ovaries are prolapsed into the pouch of Douglas, and cause severe dyspareunia, which

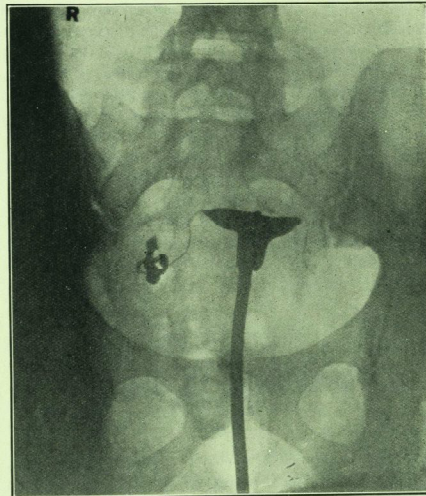


FIG. 2.—X-RAY PHOTOGRAPH OF UTERUS AND FALLOPIAN TUBES AFTER INJECTION OF LIPIODOL. THE RIGHT TUBE IS PATENT; THE LEFT TUBE IS BLOCKED AT THE JUNCTION BETWEEN ISTHMUS AND AMPULLA.

itself is a common cause of sterility. In cases of sterility with a retroverted uterus it is justifiable to antevert the uterus and fit a Hodge pessary which should be worn for a few months; if after this time the uterus does not remain in the anteverted position an operation for suspension of the uterus should be considered.

In cases of congenital abnormality of the cervix such as elongation and pin-hole or dilatation of the cervical canal may be carried out, but there is little reason in these cases for curetting the endometrium as well, for there is no evidence that the endometrium is diseased. Coitus should take place a few days after the dilatation, which should be performed on the seventh to twelfth day of a normal twenty-eight-day cycle.

SOCRATES AT THE FESTIVAL DINNER.

(With humble apologies to Plato and Jowett.)

TWENTY days had gone by since Socrates landed after his visit to England. Almost every evening had been taken up with hearing accounts from him of the people, the government, the learning, and the art of that remarkable country.

And now Eryximachus had his desire. We were gathered at his house to hear from Socrates something of the practice of medicine in England. Eryximachus was bursting with questions about the innumerable English "degrees", the General Medical Council, the hospitals, the schools of medicine—hardly realizing that Socrates, with all his wisdom, was not a fellow physician.

"No," said Glaucon, "let Socrates speak as he likes; after all, Eryximachus, even if Socrates could answer all your questions, many of his replies would be unintelligible to the rest of us, for we are not physicians."

"That is reasonable enough," said Eryximachus, "and I suppose, Socrates, that I can talk with you privately at some other time about matters that are not of interest to all."

"Most certainly, though I cannot promise to answer one-half of all you may ask. But I must thank Glaucon for his words, and with your permission I will take my own course. There is much to say, and this pleasant symposium will have to be repeated many times if you wish me to exhaust all that I saw and heard of the English physicians and their ways."

"Let me begin by telling you of a medical feast that I went to some weeks after arriving in London. I was invited to it by the senior physician of a famous, though not very ancient hospital. Soon after sunset, I was taken by my host to a magnificent temple-like building, larger than the Parthenon, though not so beautiful. But I must not do more than say that this was the hotel where the 'Festival Dinner' was held, and that I felt a little awkward in my faded tunic among so many men of noble bearing dressed in what they call 'tails'. My host told me that it was a 'stag' dinner—which means all men. You will believe me when I say that I found English a difficult language."

"After some modest drinking of 'cocktails' we found ourselves seated in a great hall at long and gaily decorated tables. I was placed on the right hand of a most gracious and cultured nobleman—my host told me that he was the president of the hospital. The names of all the guests were graven on the 'menu', and among them were people that one would hardly expect to find connected with a hospital. There were two or three

The vaginal secretion is acid to the extent of pH 4.5-5.5; such a degree of acidity is inimical to spermatozoa, but during a normal coitus the spermatic fluid and the alkaline secretion produced by the mucous membrane of the cervical canal are sufficient to neutralize the acidity in the vagina. A degree of acidity of pH 3.7 is lethal to spermatozoa, and is occasionally found in the vaginal secretion. Hyperacidity may be treated by vaginal douches of weak sodium bicarbonate solution, or, better still, by a douche of normal saline given a few hours before coitus takes place, at the period of ovulation.

Infections of the cervical canal are a predisposing cause of sterility, for it has been proved that the mucus from the infected area is lethal to spermatozoa. In such cases treatment of the cervicitis is essential.

The sterility rate is greatly increased in cases of fibroids of the uterus, which should be removed by myomectomy in selected cases.

The treatment of sterility by hormones has received considerable attention in recent years. The administration of large doses of œstrin, by intramuscular injection, is rational if given to patients who suffer from the various forms of under-development of the uterus, and results are claimed from the use of 1000 rat units of œstrin given daily on the fourth to eleventh days of the normal menstrual cycle.

Vitamin E, in the form of wheat germ oil, may be administered over a long period, but it is probable that the average diet of healthy persons contains a sufficient quantity of this vitamin to promote normal growth and development of the ovaries.

The anterior lobe of the pituitary gland controls the normal ovarian cycle and, in recent years, a so-called "stimulating dose" of X-rays has been administered to the pituitary gland, as a method of increasing the output of the anterior lobe secretions which control the ovarian cycle. This method of treatment of cases of sterility, where there are no abnormal physical signs in the pelvis, has been tried in certain clinics on the Continent and in America with fair success and is worthy of trial, but in this country an insufficient number of cases have been treated in this way to give an indication of the percentage of successes likely to be obtained.

JOHN BEATTIE.

P.P.

Mary has another cup.

I see no reason why

Next year there should be any left

For me or Tom or Guy.

BART.

great athletes, a golf champion (I cannot stop to explain to you what golf is), a cartoonist, a famous actor, a newly-made noble who attained to great wealth through the sale of pork pies, and many others. A few lesser potentates called mayors, and, as you would expect, many physicians and surgeons. Before each one of us was a silver pen and a curious unsealed envelope; on the outside of mine was written 'Prof. Socrates'. The rare foods, the many wines we drank, the entrancing music, sometimes martial, at others soft and seductive, are among my happiest memories. But the important part of the feast was the speeches. The President made a kindly speech of welcome, and then told us something of the work and of the needs of his hospital. Other speakers dwelt on the same subject, and it became very evident that the real purpose of the symposium—festival dinner, I mean—was to ask for money to continue the work of the hospital."

Here Socrates was interrupted by Agathon, who said, "Don't tell us about *their* speeches—tell us what you said when you replied to the toast—"The Guests, coupled with the name of Professor Socrates'."

"Yes, let us hear it," we all cried; "it must have been the best speech of the evening."

"The London papers did not think so," said Socrates, "and I was not going to tell you anything about it—for I am sure you would be more interested to hear what the Mayor of Popwick and the pork-pie peer had to say."

"But one paper reported you in full," said Agathon; "here is the cutting from the *Daily Herald*."

He handed it to Socrates.

"I have not seen this; the *Times* and the *Telegraph* said something about my living up to my reputation as an after-dinner speaker, but they said nothing about the substance of my speech, which, possibly, was not surprising. I do not know this paper; it must be different from the others. Yes, if you wish, I will read you what I said; it seems to be here in full:

"Your Grace, my Lords, . . . No, I will miss all that out and come to the main part of my little address. . . . 'As you may know, my chief occupation is to seek after truth, and though I do not know what truth is, yet it is the only subject on which I can speak. You must bear patiently with such a narrow-minded man (at this point some said "Hear, hear", others "No, no", but they all intended to be encouraging and courteous). I speak the truth when I say that your hospital is saving the lives and guarding the health and happiness of thousands of people, and that the work of your physicians and surgeons is altogether admirable. It is good, beautiful, and true. But there is one thing that I must question, for I cannot see even a faint

glimmering of truth in it, and therefore it must be examined. Let me ask you all—is this a *festival* dinner? Although much has been said about the work of the hospital that is a cause for rejoicing, the real purpose of this feast is to reduce the hospital's appalling debt of £22,000. The hospital has no money. Some comes in, but it is as quickly spent. Is this a cause for rejoicing—for a festival? We have heard that wards may have to be closed; the out-patient rooms are much too small; the theatres are out of date. And there is no money.

"Now it is readily admitted that a hospital is as necessary a part of the national defences as a warship; for the enemies that the hospital fights are ever at war. Death and disease continue to hurt your people however peaceful and prosperous they may appear to be in other respects. Yet when a new battleship is needed, do you have a festival dinner and make speeches to say that the Navy is so out of date that it will be in dire distress unless a number of wealthy men give of their substance to help pay for the new vessel? No. The money is provided by the Government. You are taxed—the battleship is built.

"In time of war the protection afforded by this battleship is available for all. The rich man has paid more for his own protection than the poor man, who is less heavily taxed. Consider now the voluntary hospitals. The provision for the poor is princely; the provision for the middle class, sometimes good, too often bad, and always expensive relative to the man's means; for the rich, not so good as for the poor, and most costly. How curious that all the advantages so jealously claimed for the voluntary system are enjoyed to the full only by the poor!

"Your hospital is now voluntary only in name, and as regards the visiting staff. Yet the name is valuable, for it enables you to appeal for money in all sorts of ways; a sad example of one way is our gathering to-night. Why not abandon this archaic system? As an individual hospital—impossible. In concert with every voluntary hospital in London—difficult but worth while. There is nothing to prevent you apart from your English hatred of united action for the common good. The rest of the country could be left to itself. London is great enough to act alone; the rest would follow.

"State aid—still more State control—frightens you, though I am told that some would welcome it. You seem ready enough to receive State aid for research work and to appreciate the work done by the Medical Research Council. But even if anything approaching State control is so abhorrent there is another way—one that has been carried to perfection in at least one great

foreign centre. A hospital may become a self-supporting institution, drawing its patients from all ranks of society, asking and receiving such payment from them as to enable every branch of the work to continue without let or hindrance. In this country it should be possible for the poor to be paid for by the State, the middle class by private insurance, and the rich paying out of their abundance

"Think now of the ease of your work under such conditions. No hurried journeys between consulting-room, nursing homes, and hospital; all your work under one roof; an assured income. Now you struggle to get through the routine work. There is no time for contemplation, for reviewing your results, for co-operation in your work. Only a short time ago two of your great men bewailed the lack of progress in the fight against cancer; one of them said that one form of this dread disease was being treated by as many as twelve different methods in the same hospital, no attempt being made to determine which was the best. This cannot be due simply to vicious individualism, but rather to everlasting busyness making united action impossible.

"Some of you are approaching the retiring age. You are comfortably off; maybe you feel that time will hang a little heavily on your hands. Tending a rock-garden at your cottage in the country will not satisfy you for ever. Here is a grand field for enterprise—to reconstruct your hospital system on a rational basis. To supersede with something better a venerable but outworn system famous for many things—its love of freedom, its free but often fruitless individualism, its duplications and waste, its drain upon the time and energy of the medical staff, the sweated labour of its nurses, its ingenuity in collecting money by means dignified and undignified.

"When you have accomplished your task, then meet for a real Festival Dinner."

"I think, Eryximachus, that the champagne may have caused me to talk too freely; it is a wine that I have not yet learned to drink. I must have said too much—for there were many angry faces around the tables as I sat down. My host, the senior physician to the hospital, was clearly displeased. While I was speaking I noticed that he scribbled a little message on the back of a menu, and pushed it to a friend sitting opposite, who read it, smiled a little and then nodded. Later I discovered that the message had been written on my menu card, which I had to keep for Xantippe; you may know that ever since she visited America she has been a great trophy hunter. Here is the card and the writing. Do you know what it means, Eryximachus? It passes my understanding."

I leaned over Eryximachus's shoulder as he looked at the card, and this is what I saw:

R.

Succ. Conii Fort. ʒij
Fl. haust. statim.

Prof. Socrates.

D.H.

H. J. S.

A SURVEY OF THE MODERN TREATMENT OF PULMONARY TUBERCULOSIS.

TUBERCULOSIS of the lungs, generally a chronic disease, is acute in the strict sense of the word only in miliary tuberculosis and in the severe multiple caseous broncho-pneumonia and lobar pneumonia. In a larger sense of the word one may add also those acute conditions with fever, and rapid developing symptoms of inflammation and advancing destruction. The acute generalized miliary tuberculosis with infiltration of the meninges is, in spite of a few described cures, therapeutically and invariably hopeless.

Acute miliary tuberculosis of the lungs, without affection of the meninges but with extra-pulmonary localizations, is curable, especially after the age of childhood or puberty, but these cases are rare. The treatment follows the lines of the general treatment of tuberculosis.

In cases of acute tuberculosis of the lungs, the general treatment, as prescribed by Brehmer, Dettweiler and Turban is the basis of all therapy, and may be described as follows: Absolute rest in bed, especially when the disease is accompanied by raised temperatures, the patient slowly getting acclimatized to open-air treatment, first in bed in the room, then in a bed on the balcony. The success of this treatment is manifested in the disappearance of the toxic symptoms, improvement of the general condition, and increase of immunity and resistance. The open-air treatment must naturally be supplemented by ample nourishment, varied and rich in calories and vitamins. Special diet is indicated only in the case of complications.

A regular daily programme facilitates the carrying through of a cure, and helps the patient towards self-discipline.

A real systematic cure is only possible in a sanatorium. For the acute forms of tuberculosis a climatic cure is of great importance. Propaganda for curing this disease at home is absurd. The advantages of the Alpine climate are well known and proved, and it is established by years of experience that the High Alps are indicated

especially in early cases of the acute stage with infiltration, and even also for the extensive processes of broncho-pulmonary and pulmonary tuberculosis. This climate strengthens the general organism and improves the resistance. Other results are resorption of the exudative and infiltrative seats of the disease.

Hydropathic measures are advisable for the care of the skin, and to help to combat fever and night sweats.

Heliotherapy is not indicated in cases of acute forms of pulmonary tuberculosis, nor is the treatment by X-rays. Quartz lamps may be used, but with great caution.

Specific tuberculin treatment and specific stimulant therapy are contra-indicated in cases of super-sensitive types. In subacute and chronic cases both of these may be tried with safety and advantage.

Of chemo-therapy, especially as regards gold preparations, the same may be said. Sanocrysin, with regard to its possible complications, is not advisable, whereas Aurophos and Solganal B. oleosum are to be recommended as useful and safe.

Collapse therapy is of great value, especially in acute forms of pulmonary tuberculosis. Of the collapse treatment, artificial pneumothorax is the form of choice. In all more or less unilateral cases artificial pneumothorax must be taken into consideration if previous conservative treatment has not quickly had the proper effect. Favourable results may be obtained, even in cases of rapidly progressive caseous pneumonia, although there is, in these types, always a risk. Double simultaneous artificial pneumothorax may be attempted with good results in cases of bilateral diseases. The value and scope of artificial pneumothorax has been enormously increased by the present method and improved technique of the cauterization of adhesions, thus enabling a complete collapse to be obtained in many cases, when otherwise impossible.

Phrenicectomy is very useful in certain cases when a pneumothorax has failed owing to adhesions and has a favourable action in paralysing the diaphragm, so resting the lung and promoting fibrosis.

Extra-pleural plombage or apicolysis aims at the local closure of an apical cavity by means of an extra-pleural wax plug, and is in suitable cases a most useful and not a severe or risky form of intervention.

Thoracoplasty is only indicated in unilateral cases of subacute and chronic forms with a tendency to retraction.

To summarize: General treatment in sanatoria in the High Alps, combined with collapse therapy when indicated, leads to favourable and very good cures, which are successful and lasting in a great number of instances.

BERNARD HUDSON.

NEUROFIBROMATOSIS: A REPORT ON THREE CASES.

INTRODUCTION.

THE disease is commonly called by the name of von Recklinghausen, who first described its typical clinical appearances in 1882 (1). It was, however, known for at least half a century before his time, and one of its varieties was placed on record by Cheselden (1) in 1740. The most complete early description, with numerous illustrations, was made by R. W. Smith in 1849, his article being considered worthy of repetition in full in 1898 (2).

The comparative rarity of the disease combined with its unusual and varied appearance has stimulated the production of several excellent monographs (1, 2, 3), and some hundreds of cases have been described in recent years. The disease is of congenital or developmental origin, and characterized by cutaneous nodules, diffuse pigmentation, nerve-trunk tumours and, more rarely, by plexiform neurofibromata, elephantoid conditions of limbs, osseous changes, affections of mucous membranes, and a variety of congenital abnormalities and endocrine disturbances.

Several cases are attending the Out-Patient Department, and three typical cases were recently in the wards and merit description.



FIG. 1.—CASE 1: Æt. 7. KYPHOSCOLIOSIS AND PIGMENTATION.

CASE 1. N. S.—, an unmarried Russian Jew, æt. 32, was admitted under Mr. Elmslie's care on February 14th, 1934, complaining of inability to walk, loss of sensation below the navel, constipation, and difficulty in passing water.

History of present condition.—Apparently normal at birth, apart from several large brown patches on his left thigh.

Æt. 1½: Gradual onset of curvature of the spine following a fall down three flights of stairs.

Æt. 4: He was "run over by a car", and since then the right side of his face and skull have slowly assumed their present grotesque contour. His right eye underwent painless enlargement with impairment of vision, which was finally lost at the age of 19.

Æt. 8-15: His curvature being extreme (Fig. 1), he wore a spinal jacket, and attended a school for physical defectives.

Æt. 12: New pigment patches on abdomen. On leaving school he became a commercial traveller, and did not wear a spinal jacket.

Æt. 18: Commencement of impaired hearing on right side.

Æt. 26: He developed symptoms of paraplegia and attended the London Hospital. He was sent to Mr. Elmslie, 6 months on a plaster bed and 3 months in a jacket entirely relieved his symptoms, and he returned to work for three years (without a jacket).

Æt. 25-29: Pigmentation of limbs. Sun-bathing has produced permanent freckles. Onset of skin tumours and two soft swellings in mouth, the latter following some months after removal of carious teeth. He volunteered that he has frequently noticed profuse sweating, limited strictly to the right side of his face and forehead. Hearing decidedly worse on the right side, while occasionally there is a hissing noise in this ear.

Æt. 29: Return of paraplegia. No adequate hospital treatment for nearly two years. "Crawling about" at home. Finally seen by Dr. Parkes Weber in January, 1934, and sent back to Mr. Elmslie.

Past history.—No evidence of endocrine disturbance; no serious illness.

Family history.—His mother is said to have several pigmented "birth-marks", but neither parents nor any of his twenty cousins have the typical appearance of neurofibromatosis.

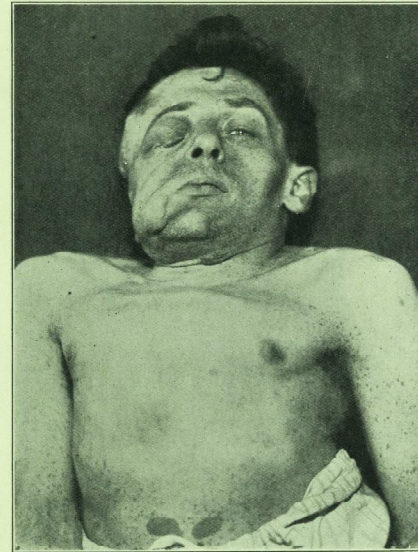


FIG. 2.—CASE 1: Æt. 32. FACIAL DEFORMITY; PLEXIFORM NEUROFIBROMA; PIGEON-BREAST AND PIGMENTATION.

Condition on Examination.

Bright, intelligent man of a sensitive disposition.

Head: On the right side of the face there is a large swelling 9 in. by 9 in. External auditory meatus almost blocked. Skin very loose—3 in. redundant. Tubular strands felt subcutaneously—"bag of worms" sensation. Deep to this, extending from thyroid cartilage to angle of jaw, are 8 mobile gland-like bodies of firm consistency, tender if compressed. Underlying but not attached to the upper part of this plexiform neurofibroma there is a bony ridge ½ in. raised on the frontal and temporal bones, running obliquely back and laterally from the middle of the eyebrow for 4 in. The right zygoma feels less prominent than the left. There is a deficiency in the outer table of the occipital bone, 1 in. diameter with irregular edges.

Right eye: The upper lid is involved in the skin condition described above, and the whole eye prolapsed ¼ in. owing partly to the weight of the adjacent mass. Ocular movements diminished in all directions. The eyeball is large, and there is a staphyloma ½ in. below the lower margin of the iris, which is dilated and fixed. There

is a central corneal opacity, and the sclera is blue and congested. The conjunctival secretion is muco-purulent.

Left eye: Left side of face and skull normal.

Mouth: Mucous membranes not pigmented, tongue normal. Some carious teeth, pyorrhoea, fœtor oris. Protruding from the gums in the region of the upper and lower right molars, which were

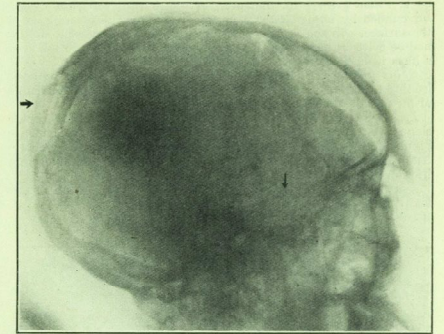


FIG. 3.—CASE 1: Æt. 32. FRONTAL EXOSTOSIS; DEFICIENT OCCIPUT; LARGE PITUITARY FOSSA.

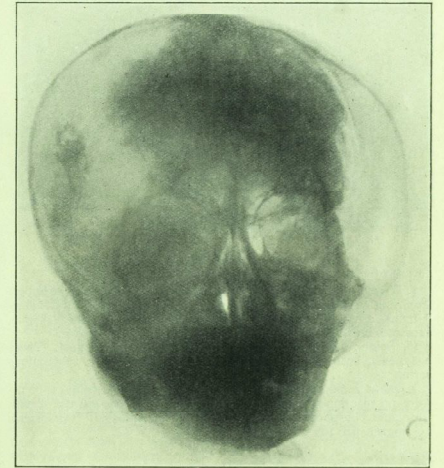


FIG. 4.—CASE 1: Æt. 32. RIGHT HEMI-HYPERTROPHY; VERY LARGE RIGHT ORBIT; MANDIBULAR EXOSTOSIS.

removed six years ago, there are two soft, non-fluctuant masses ¼ in. by ½ in., hanging free and covered by normal epithelium. No local septic cause. Directly underlying but not attached to the lower one is an exostosis of the mandible ½ in. by ½ in., of smooth surface. The hard palate is markedly asymmetrical; epiglottis easily seen.

Cranial nerves: N.A.D. apart from right-sided blindness.

Skin: (a) **Pigmentation:** Present on trunk, limbs and neck, slightly more marked in parts normally pigmented, but unrelated to pressure points, and absent from palms, soles and face. Size: Pin's head to $\frac{1}{4}$ in. Several large (3 in. diameter) café au lait patches on abdomen and outer side of right knee.

(b) **Nodules:** One on each forearm, two on right thigh, one on back. Size $\frac{1}{2}$ in. in diameter, of bluish tint, soft, not cystic, surrounded by unpigmented skin, and containing no opening on to the surface. In the suprasternal region there is a somewhat similar nodule with an acneiform "head", which is said to have followed a burn from a cigarette.

Spine and chest: Extreme kyphosis and considerable scoliosis leading to marked prominence of the chest and apparent shortening of the neck. No evidence of spina bifida.

Legs: Spastic, knee-jerks ++, ankle-jerks ++, P.R. 7, ankle clonus +. Partial anaesthesia up to umbilicus (F. 10). No evidence of plexiform or periosteal neurofibromata. No nodules on nerve-trunks. A cyst on dorsum of right foot apparently came from friction against his shoes.

Heart, lungs, abdomen, pelvis, testes and urine showed no abnormality. B.P. 133/85.

Ductless glands: N.A.D.

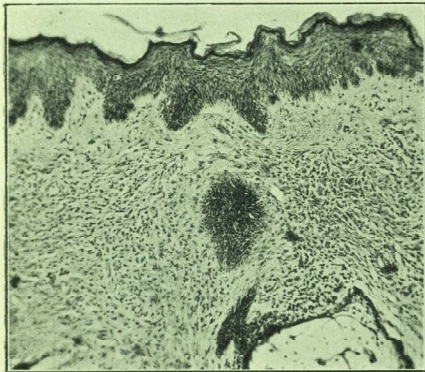


FIG. 5.—CASE 1: SECTION OF PLEXIFORM NEUROFIBROMA.

Investigations.

1. **X-rays.**—(a) Skull (see Figs. 3 and 4): Right hemi-hypertrophy, a very large pituitary fossa (33 by 15 mm., normal 14 by 8 mm.), a very large right orbit, deficient bone in the occiput, exostoses on the mandible and frontal bones are well shown.

(b) **Spine:** Gross kypho-scoliosis, vertebrae wedge-shaped. There has never been X-ray evidence of healed or active tuberculous caries.

2. **Blood examination.**—(All results within normal limits.) Wassermann reaction negative. Calcium 10.2 mgrm. per 100 c.c. serum. Inorganic phosphorus 4.2 mgrm. per 100 c.c. plasma. Cholesterol 195 mgrm. per 100 c.c. blood.

Diagnosis.

Von Recklinghausen's disease and compression paraplegia.

Treatment.

Gradual improvement occurred during 11 weeks' recumbency on a plaster bed. Meanwhile his appearance was improved by excision of an elliptical piece of skin redundant 1 in. wide by 3 in. long from the right side of his face by Mr. McIndoe. This raised the level of his right eye nearly to that of his left. On discharge he could walk, but still with some stiffness. Sensation and sphincter control were recovered. A spinal jacket was fitted for permanent use. Recent examination has shown gradual improvement.

Pathology.

The piece of skin removed was thick, moderately vascular, and loosely attached on its deep surface, which presented numerous thick strands of interlacing fibrous tissue. The section showed a very cellular fibrosis in the subepithelial connective tissue, with a few nerve-fibres and lymphocytes. There were no whorls of fibrous tissue and no new nerve-fibrils (Fig. 5).

CASE 2. R. B., a warehouse porter, et. 49, was admitted to Smithfield Ward, c/o Dr. Geoffrey Bourne, on January 17th, 1934, complaining of paralysis of right side and difficulty with speech.

History of present condition.—Normal at birth, except for a sheet of brown pigment on left thigh.

Et. 17: Injury to back. Admitted to Kenton Ward, where he spent 2 weeks in a plaster jacket. Shortly after discharge he developed numerous cutaneous nodules and kypho-scoliosis, both of

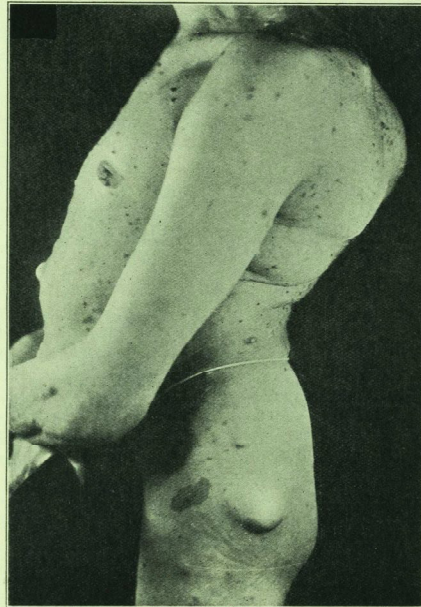


FIG. 6.—CASE 2: KYPHO-SCOLIOSIS; NEUROFIBROMATA AND PIGMENTATION.

which conditions have steadily but painlessly increased to an extraordinary degree. During recent years a few of the nodules have become brown. His spinal deformity has not debarred him from vigorous exercise.

Et. 39 (5½ months ago): In usual health when he had a fit. Tremors and loss of control of right arm; inability to formulate the words he wanted to say; stiffness and dragging of right leg, but without loss of consciousness. Although standing at the time he avoided a fall by clutching some support. Weakness decreasing, he remained at light work. He was unable to control right hand for writing. There was severe headache and constipation.

Three months ago, second attack; more severe; mouth dropped on right side, tremors of right eye and arm. Remained at home; able to walk 100 yards with a stick, but "sagged" over to right side. Misty vision; no vomiting.

Five weeks ago: Unable to read print.

Treated with massage, radiant heat, electricity and luminal until admission.

Past history.—Six years ago: Frontal headaches and photophobia—recurring attacks.

Four years ago: Following influenza, eight months' chronic suppurative otitis media on left side, latterly causing giddiness and nausea. Mr. Just performed a Schwartze for subacute mastoiditis, and opened an extra-dural abscess in the posterior fossa. Headache relieved for over three years, until onset of "fits". No further aural discharge.

Family history.—No history of cutaneous nodules or pigmentation.

Condition on Examination.

Healthy-looking man with a mottled complexion, T.P.R. normal.

Mouth: Carious teeth; tongue furred; fauces oris.

Skin: Multiple sessile and pedunculated nodules, most numerous on trunk and face, and of variable size (see Fig. 6). Some are firm, and others show umbilication and all stages to degeneration and discharge of white necrotic material from an acneiform ostium. Some are covered with brown pigment. There is a large sheet of pigment on the left thigh, but small patches are absent, apart from the nodules.

Spine: Gross angular kyphosis in the mid-dorsal region, accompanied by marked scoliosis, with resulting chest deformity and opening out of the costal angle.

Central nervous system: Speech slow; dysphonia and dysarthria. Annesia verbalis. Intelligence, reading and correlation good. Writing difficult owing to spasticity of right hand and arm.

Cranial nerves:

II. Visual acuity fair; fields normal. Early papilloedema, more marked on left.

III. Slight ptosis of right eyelid, pupils R./L.A.

V. Right corneal reflex absent. Vinegar tasted like honey; sugar no taste, salt recognized. Weak right masseter. Sensation and salivation normal.

VI. Fine nystagmus to right. No diplopia.

VII. Right side of face expressionless; weak right orbicularis oris et oculi. No hyperacusis.

VIII. (a) Auditory left: bone-conduction greater than air-conduction. (b) Vestibular left: no nystagmus after syringing with cold water.

IX. Palate weak on right.

Cranial nerves I, IV, X, XI, XII, right VIII and the cervical sympathetics appeared normal.

Reflexes: Increased on right side (supinator, biceps, triceps, knee-jerks, ankle-jerks), P.R. 4, ankle clonus on right. Lower abdominal reflexes absent.

Tone: Increased in both arms, especially right and in right leg. No wasting.

Muscle power: Weak right arm and leg. Dynamometer: Right hand 45, left hand 110.

Sensation: Impaired in right forearm. Some loss of deep pain.

Co-ordination: Poor on right side: dysdiadochokinesis; astereognosis.

Gait: Dragging of right leg. Rhombic negative.

Neck, heart, lungs, abdomen and urine N.A.D. B.P. 135/110.

Investigations.

A. When admitted in 1930.

1. X-ray (see Fig. 7). Gross kyphosis of mid-dorsal region forming a sharp angle of 62°. Marked scoliosis. No definite evidence of tuberculous caries.

2. Removal of skin tumour and section. Vascular, soft, cutaneous fibroma. No histological evidence of connection with nerve sheath otherwise typical of neurofibromatosis.

B. During present admission.

1. Cerebro-spinal fluid clear, no clot. Pressure 160 mgrm. water. Two lymphocytes per c.mm. Protein 90 mgrm. %; globulin absent.

2. X-rays: A direct X-ray of the skull showed some absorption of the posterior clinoid process.

Diagnosis.

Von Recklinghausen's disease and a cerebral tumour were diagnosed, but the latter was difficult to localize. Absence of right corneal reflex, infranuclear paralysis of right facial nerve, weakness of right side of palate and nystagmus towards the right, seemed to

point to a site in the right posterior fossa. But the fact that the right VIII was normal, and the presence of Jacksonian fits of right face, arm and eye, right hemiplegia (face and arm > leg) and motor aphasia, all indicated that the left cortex was the more likely position. A relationship to the old extradural abscess in the posterior fossa was considered possible, but unlikely. Meningioma, glioma or tuberculoma were amongst the more probable causes.

Treatment.

Ventriculography and exploration were recommended. Operation February 5th, 1934.—Mr. Paterson Ross. Local anaesthesia.

The left parietal eminence was burred, and a ventricular needle passed down, in and forwards towards the sella turcica. At a depth of 34 cm. from dura, 25 c.c. of yellow fluid were evacuated from a

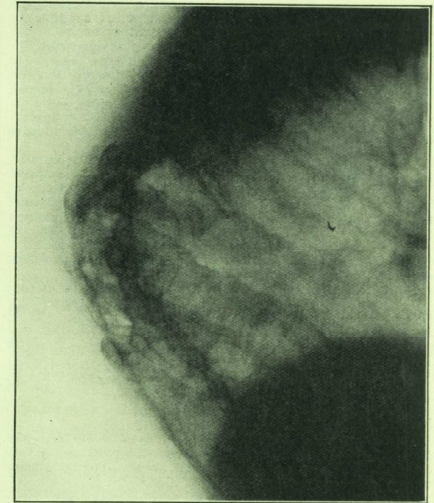


FIG. 7.—CASE 2: ANGULAR KYPHOSIS (LATERAL VIEW).

gliomatous cyst, and replaced by 8 c.c. of air. Dura no longer tense. X-ray showed air deep to and just behind left motor area.

Further treatment.—Radical removal being impracticable, a full course of deep X-ray treatment was given.

Progress.

Steady improvement during next six weeks. When discharged on March 16th, 1934, he could say most words intelligibly, if slowly, and could write better; he had less facial paresis, and was recovering muscle power, sensation and co-ordination. He was readmitted two months later as he had had two fits in the previous five weeks, with return of other symptoms. He could still walk well. Rapid improvement after aspiration of a further 17 c.c. of thick yellow flaky fluid from cyst. Discharged in 2½ weeks.

CASE 3.—H. M.—, et. 33, was admitted, c/o Mr. Foster Moore, on June 18th, 1930.

History of present condition.—Normal at birth.

Et. 0 months: Fell downstairs, and dates displacement of eye from this. Gradually becoming worse. Right eye pulsates and gets more prominent, especially during emotion.

Et. 7: On the supposition that a vascular retrobulbar swelling was the cause, Krönlein's operation was performed, the right orbital margin being enlarged laterally. As no improvement occurred, the

right internal carotid was ligatured a few weeks later. The operation proved unsuccessful, and the patient has sought in vain for further surgical help at five different hospitals. It is remarkable that his sight is equal and good in both eyes, and he never "sees double". His chief inconvenience has always been difficulty in getting employment.

Æt. 20: First cutaneous fibroma on abdomen. Painless widespread appearance since. Apart from occasional frontal and occipital headaches his general condition is excellent.

Past history.—Measles, whooping-cough, "croup".

Family history.—No pigmentation, fibromata or congenital abnormality. F., M., 2 brothers, 2 sisters a/w.

Condition on Examination.

Average build, a dark complexion and sandy brown hair. Skin nodules very numerous; trunk more than legs. Skin texture overlying the nodules varies from normal to a thin transparent appearance; colour brown, red or normal. No pigmentation apart from nodules.



FIG. 8.—CASE 3: PROPTOSIS.

Nerve-trunk tumours fewer, but numerous. Size $\frac{1}{2}$ in. → in. Movable in only one direction. The largest one in left hypochondrium was 2 in. diameter, dependent, and in appearance and texture resembled a breast with 4 nipples.

Eyes: Right markedly proptosed down and in; optic nerve palpable behind. Eyelids can be closed over it; ocular movements full; visual field and fundus normal. Pulsation felt, but no bruit heard. Scar of operation at outer canthus.

Left: No proptosis. Fundus: Opaque nerve-fibres at 12 o'clock above disc. Visual acuity $\frac{5}{6}$ on both sides.

Skull: Mongolian type. Measurements: Circumference 61 cm., length 20 cm., breadth 16.4 cm. Cephalic index = $\frac{1040}{20} = 82$

(breadth \times 100)
length

Neck: Scar of old operation on carotid artery. Mouth, heart, lungs, abdomen and central nervous system: N.A.D. Urine: No albumin. Benedict turned green.

Investigations.

1. X-ray.—Bone very thick. Right orbit considerably larger and denser than left. Orbital walls normal. Pituitary fossa poorly defined; right fronto-ethmoidal cells absent. Frontal sinuses normal.

2. Fasting blood-sugar, 106 mgrm. %.

Diagnosis.

Von Recklinghausen's disease. The enlarged orbit transmitting pulsation from the brain is a recognized congenital abnormality of bone associated with this disease (5).

Treatment.

None recommended.

DISCUSSION.

Ætiology.—The disease is of developmental origin (6), and may show itself *in utero* or at any age. The fundamental cause is unknown, as there is no constant finding in the reported cases. Almost every endocrine disturbance has been associated (7) with the disease, but in many cases there is no evidence of such. There is at present no positive evidence for a metabolic defect such as is present in ochronosis and alkaptonuria. Syphilis and other infections appear to play no part in causation, though the latter may affect the prognosis (*q.v.*).

Pathology.—The neurofibromata are of connective-tissue origin, and the communication between the tumours and nerve-sheaths can usually be proved in cerebral, nerve-trunk and plexiform fibromata, but it must often be assumed in the case of the cutaneous nodules. The nevus cells are of ectodermal origin (8); fibrous tissue being mesodermal, there is, therefore, an over-production of both of these elements in von Recklinghausen's disease. As both nevus cells and fibrous tissue are found closely associated with the sensory nerve-endings, it is extremely probable that this is the site (7) of the lesion in the epidermis. Endoneurium (7) is more commonly affected than epineurium on nerve-trunks, while intracranial tumours arise from nerve-sheaths, dura or neuroglia (7). Exostoses probably result from periosteal nerve-tumours (6), which may detach osteogenetic cells.

Associated congenital defects.—Skull deformities, meningocele (6), spina bifida (6) and glaucoma (buphthalmos) occur, the latter being associated with multiple ciliary nerve-tumours (5). Deficient orbital walls may occur with this or with pulsating exophthalmos. Megacolon and giant appendix (9) are rarities, while sexual and mental defects are common (7); 27% are sterile, and among the rest "one-child sterility" is the rule. Miscarriages, premature and stillbirths, deaths in infancy, asexuality, cryptorchidism, infantilism and impotence are all more frequent than normal. 8% are feeble-minded (ten times the normal incidence) (7).

Hereditary factors (7).—A minority are familial, transmission being then usually a dominant Mendelian factor carried equally by either sex. In some of these cases pigment and tumours occupy similar positions in succeeding generations. Hereditary neurofibromatosis is also seen in cows, horses, deer and dogs. Its world-wide sporadic occurrence, involving even the "unmixed" races, is, however, evidence in most cases for the mutational theory.

Clinical Features (6).

(1) **Skin and mucous membrane fibromata.**—Cutaneous nodules number one to thousands, and vary from military to the size of a melon. Though normally spherical, soft, smooth and raised, they may be either level or pedunculated. Degeneration, with discharge of necrotic material, is commoner than vasculature. The trunk is more affected than the limbs, while palms and soles escape (10). Mucous membranes are rarely affected, but nodules have been found in the stomach, duodenum, ileum, bladder, ureter and kidney. Colic, diarrhoea and dyspepsia have resulted (7).

(2) **Pigmentation.**—Deposits of melanin occur in the skin, usually separate from the nodules. A few patches,

several inches in diameter, and many the size of freckles, are common findings. Often blue at first, they later become brown or red, while depigmented areas (nevus anæmicus of Verner (7)) are very rare. Mucous membranes always escape.

(3) **Tumours on nerve-trunks** (7).—Varying greatly in size and number, they may affect any nerve, but are rarely seen without the more frequent cutaneous nodules. Mobility at right angles to the nerve and fixation longitudinally are characteristic. Though often symptomless, they can lead to pain, tenderness, increased or diminished nerve function. For example, involvement of the cervical sympathetic causes unilateral sweating or flushing of the face (11), while auditory nerve tumours may result in bilateral deafness. Cough, aphonia, hoarse or irregular breathing are an occasional outcome of tenth nerve fibromata, and lingual tremors of twelfth nerve tumours. The cauda equina, spinal nerve-roots and abdominal sympathetic plexus are not infrequent sites.

(4) **Plexiform neurofibroma.**—In this rarer condition all the nerves to a certain area are thickened and palpable as subcutaneous cords. The bulky, dependent mass frequently overlies a separate exostosis or nerve-trunk tumour. The fifth nerve distribution is more often involved than the limbs and abdomen (10), and hemihypertrophy of tongue, lips or face is sometimes seen.

(5) **Cerebral tumours** (7).—Single or multiple meningiomas and less commonly gliomas have occurred throughout the brain and spinal cord, and besides localizing signs, may produce progressive dementia, epileptiform attacks and hysteria.

(6) **Bone deformities** (12).—Kyphoscoliosis is not infrequent and tends to gross angularity, which may cause pressure symptoms (Case 1). Of unknown cause, it might be classed with the similar deformity seen in syringomyelia. Large irregular exostoses may be produced on the skull or limbs, while coxa valga, softening and bending of pelvic and limb bones are additional possibilities. Bone cysts may cause deficient growth, if involving the epiphysis, or lengthening, if in the shaft, perhaps by increasing the blood-supply. These cysts are quite distinct from those found in Von Recklinghausen's disease of bone (osteitis fibrosa). The former are degenerating neurofibromata, whereas the latter are accompanied by generalized decalcification and parathyroid tumours.

(7) **Elephantiasis nervorum.**—This is very rare, and usually complicated by periosteal and plexiform masses. The whole of a limb is grossly enlarged by masses of fibrous tissue which replace the fat (10). Treves's "elephant man" is the best known example (13). Eosinophilia (*e.g.* 15%) has been recorded (14).

Histology (9).—A moderately vascular, cellular, fibrous tissue is typical. In the skin the cells are arranged in streams, presenting a reticular appearance with occasional fibrous whorls at the edge (6), but the nerve-trunk tumours are denser and present parallel fibres. Even small nerve fibres are continuous through the tumours (2), which, however, very rarely contain nerve-fibrils (6). Perivascular fibrosis (6) and scattered lymphocytes are seen at times, while ganglio-neuromata (*e.g.* of the Gasserian ganglion) are of extreme rarity (6). Malignancy is heralded by insidious loss of cell streams and parallel fibres with local invasion and abnormal mitoses.

Diagnosis.—50% cases (7) exhibit both skin tumours and pigment, most of the remainder having the one or the other alone. Mild cases of the latter variety are, in the absence of a positive family history, indistinguishable from the occasional "moles" and skin tumours of normal people (6). *Nævi pilosi* do not, however, occur. In hereditary cases the other features (7) sometimes occur without pigment or nodules. Ophthalmoscopic examination may reveal opaque nerve-fibres, but these are also seen in an allied developmental defect known as tuberous sclerosis of the brain (15). Diffuse neurofibromata of the skin may be present in this disease, but sebaceous adenomata are typical (7), and pigmentation absent. Great thickening of nerve-trunks without pigmentation characterizes the rare family hypertrophic neuritis (6). Nerve-trunk tumours must be distinguished from lymph-glands and kyphoscoliosis from Pott's disease, with which it is unassociated. Lymphangioma of the face or neck may simulate a plexiform neurofibroma. The skin is not oedematous in elephantiasis nervorum, while the overlying plexiform mass (6) distinguishes the periosteal tumours from cancellous and ivory exostoses.

Course and prognosis.—Blue or brown skin spots are often the earliest (7) and sometimes the only (16) signs of the disease. Though the disease is slowly progressive, its intensity waxes and wanes (*e.g.* Case 1: Disease active prenatally, æt. 1½–15, 25–32). An exacerbation may follow any acute infection or endocrine disturbance, such as occurs at puberty, the menopause or during pregnancy (7). It seems probable that trauma (7) may determine the site of a lesion in a latent case (Cases 1, 2 and 3). Very rarely improvement (6) has occurred after pregnancy, skin tumours atrophying and sometimes leaving palpable gaps in the skin.

While some "die before they are born" (7), others live to old age. The cutaneous and plexiform tumours (10) are of no danger to life, but a cerebral tumour may develop at any time, or malignancy complicate a nerve-trunk tumour. Carcinoma, sarcoma or both may occur

simultaneously from multiple sites, and 12-17% cases die from this cause (7). Melanomata are very rare (10), but sarcomata are apt to be familial (7). This interesting fact makes Von Recklinghausen's disease an excellent example of a developmental defect associated with a congenital tendency to malignant disease. The remaining dangers arise from local symptoms of nerve-trunk tumours—blindness from detached retina, buphthalmos or pressure on the optic nerve; deafness, paraplegia and a host of other complications. The average age at death is probably about 40 in progressive cases surviving infancy.

Prophylaxis.—Even mild cases should not marry, as their offspring may develop the worst manifestations of the disease and pregnancy (7) frequently heralds an exacerbation. The acute specific fevers, chills and trauma should be avoided as far as possible. It is interesting that the disease tends to die out (7) in any given family, owing to the early deaths caused, the frequency of sterility and the unlikelihood of such hideous people being able to marry.

Treatment.—Drug and endocrine therapy being valueless, symptomatic treatment is indicated. Intracranial tumours, incipient paralyzes, malignancy and severe pain may necessitate operation. Hemi-glossectomy was required to allow of closing of the mouth in one case (11). Recurrence is the rule after removal of nerve-trunk tumours (9, 10), so that a wide margin should be left, and a course of deep X-ray treatment given. Progressive kyphoscoliosis may be prevented by a spinal jacket, and good results have been reported from operative measures for early fixation of the vertebrae concerned (10). Cosmetic reasons occasionally justify operation, as in Case I, but there is a danger of causing malignant transformation (10). Case 3 is an example in which surgery was of no value.

SUMMARY.

The following features, typical of Von Recklinghausen's disease, are present in one or more of the three cases reported:

- (1) *Skin and mucous membrane fibromata.*—Multiple pigmented and non-pigmented cutaneous nodules. Two large fibromata attached to gums.
- (2) *Pigmentation.*—Sheet type and small dots; congenital and acquired.
- (3) *Tumours on nerve-trunks.*—II, VII, VIII and cervical sympathetic: (widespread on smaller nerves in Case 3).
- (4) *Plexiform neurofibroma.*—Right side of face.
- (5) *Cerebral tumours.*—Glioma behind left motor cortex.

(6) *Bone deformities.*—Periosteal neurofibroma of frontal and mandibular regions. Kypho-scoliosis.

(7) *Elephantiasis.*—Absent.

(8) *Associated congenital abnormalities.*—Multiple skull deformities. Buphthalmos.

(9) *Family history.*—Pigmentation ("Forme frustre").

In conclusion I should like to express my thanks to Dr. Geoffrey Bourne and Mr. Foster Moore for permission to report on their cases, to Mr. Elmslie for reading the proofs of this report, which was written at his suggestion, and to Dr. Parkes Weber for much help and advice.

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A. C. KANAAR.

A LETTER FROM KENYA.

EIGHT years ago a friend told me he was going out to Kenya to buy a coffee estate. He painted a glowing description of life out there, and invited me to join him. It happened to be in the middle of the busy winter work of private practice, when it was one hard drive to get one's round into the day. The memory of those night expeditions, with the

sudden change from the comfort of a warm bed to the cold and damp of the world outside, still raises a shiver even after eight years of unending summer. I was tempted and I fell, and I have never regretted it since. I felt that the thirty years in general practice at home had earned a change.

My wife and I came out, stayed with friends and looked round for ourselves (the friend I was originally to join had died, poor fellow). Our first visit was to a coffee estate near Nairobi. My first surprise came watching the sick parade while dressing each morning. My friend, the owner, had anything up to a dozen standing in a circle and recounting their aches and pains at length—malaria, constipation, abdominal pain, cough and so on. He gravely heard what they had to say and afterwards, in every case, emerged with a mixture of mag. sulph. and about 3ij of ordinary lamp paraffin, and this draught seemed to cure all their woes. I suggested that he was taking rather a heavy responsibility in thus treating his sick, coming as I did from a country where the slightest ill among the house staff is immediately sent to the panel doctor. Since then I have found that the manager on every estate has a sick parade, where he often has to treat smaller ailments for an hour or more each morning before the work of the day begins, only the graver cases being sent to a doctor (usually many miles away) or to the nearest hospital.

From there we went up to friends owning a large dairy farm at 8500 ft. altitude—the days were warm, but every evening in the year warm clothing and a huge wood fire were most necessary and comforting.

Eventually I landed up in the neighbourhood where I am now, with the idea of having a small coffee *shamba* and doing private practice. I saw a 200-acre farm with about 100 acres already planted up with coffee and I nearly bought it. Luckily two friends put it to me that I did know something of medical work and nothing at all about coffee, and that I had better stick to the job I knew. Seeing now the general depression in prices and the lack of rain for the last two or three years, I can never be thankful enough to those two friends.

Practice here, about 30 miles from Nairobi, is always full of interest and variety, and seldom hard enough to be a tax. Most of my work is at my surgery, where I see white, brown and black.

Serious cases are sent into nursing homes or hospitals in Nairobi, and with anything obscure I can always rely on my friends at the Government Medical Laboratory, every one of whom is only too ready to help in any way he possibly can.

Here I would like to point out what an excellent service the Colonial Medical is, from what I have seen

personally in this colony at any rate. They have quite a high-grade set of men in it, who get good pay and allowances (home voyage allowance and pension), very interesting work, which is often hard, a wonderful climate and freedom from practice worries. They have every encouragement also to specialize. The only objection that I can see is that they have no settled home for more than their tour of three years or so, and on return from leave will be posted elsewhere, or, at any rate, not get the same house and garden.

I cannot honestly advise any young medical man to come out here with the idea of general practice unless he will settle in Nairobi, or in one of the few large towns. General practice in the country is all very well for a man who has private means behind him, and having put in hard work at home, wishes to help out what income he has with a part-time occupation, but I would not advise it as a whole-time job.

Although imported food, etc., costs more than at home, living, on the whole, is not expensive. One can buy a few acres of land and put up a house cheaply, especially now, when labour is far less expensive than in the past; servants are, on the whole, good and cheap, and, given a local club and a car, one's only other requirements, food and drink, are what one likes, or can make them.

A lover of sport can, as a resident, get it cheaply with a tent and a car. There is excellent trout fishing, with buck and bird shooting to be got free, except for Government licences. A friend sent me a 4-lb. trout the other day, one of three he had caught weighing 15 lb., and this only for a motor car run of 30 miles from here and a walk through lovely forest to the river—miles of it open to all for a yearly Government licence of 25s. Big bags and big fish are the rule. I have had as much buck and guinea-fowl shooting as I could wish while staying with a friend 100 miles away on his grazing farm of 5000 acres. The climate can be anything you desire, according to altitude. Here we are only 5000 ft. and the temperature varies from 60° to 85°, but on the slopes of Mount Kenya, on the equator, it is so cold at night at 7000 ft. that thick clothing and a big fire are necessary every night although the days are delightfully warm.

Medical work is very varied. On top of ordinary European diseases, one gets anything from an arm amputated by a crocodile, or lion or leopard wounds, to malaria, yaws, leprosy, etc. Here, up country, one has to have a good dispensary, because the nearest chemist is at an impossible distance away. The chief trouble with the Europeans is the tendency to leave diseases too long before seeing a doctor, either because they live at a distance, or because in the past they

have had to rely almost entirely on home treatment, and have not yet got used to near medical help.

We are passing through rather a grim time here just now in this coffee district, as rain has been scarce, prices low, and bankers unwilling to continue overdrafts. But still one can meet most of the neighbourhood at the local club at the week-end. There, cares and troubles are for a time forgotten, and one, in spite of all, is still glad to be alive and in this land of sunshine.

JOHN STERRY.

STUDENTS' UNION.

CRICKET.

ST. BARTHOLOMEW'S HOSPITAL v. ST. MARY'S HOSPITAL.
Semi-final Cup-tie.

Played away on June 24th.
Scores: St. Mary's, 174.
Bowling: Mundy, 7 for 42.

R. M. Kirkwood, c and b Morrison	9	C. G. Nicholson, c Wilson, b Morrison	0
D. J. A. Brown, c Richmond, b Thorogood	0	C. M. Dransfield, c Morrison, b Beemer	6
C. R. Morison, c Thorogood, b Morrison	3	J. D. Anderson, st Schneerson, b Beemer	12
R. C. Dolly, c Gideon, b Thorogood	2	J. B. Bamford, c Thorogood, b Beemer	2
R. Mundy, c Cockburn, b Thorogood	0	J. C. Cochrane, not out	7
G. D. Wedd, c Gideon, b Thorogood	2	Extras	3
		Total	46

Bart's lost the toss for the ground, the toss for innings, and most decidedly the match. By lunch-time St. Mary's had made 115 for 5 wickets, the notable features being a well-played 57 by Schneerson, who was brilliantly caught at the second attempt by Kirkwood at mid-off, and the extremely bad fielding of Bart's, who gave away a large number of runs, not by misfielding so much as frank laziness. By 4.15 St. Mary's had been dismissed for 174 on a wicket which had never really appeared difficult, although a number of balls had risen rather sharply.

The Bart's batting was a dismal failure, only relieved by a last-wicket stand between Cochrane and Anderson, especially a straight drive for 6 by the latter, which was the only one of the match. That the St. Mary's bowlers knew the spots in their wicket better than Bart's was suggested by the fact that more often than not they made the ball rise head-high, and of the nine batsmen who were caught, seven were out from bumping balls.

The best bowling performance of the day was by Mundy, who in 24 overs took 7 wickets for 42 runs. The St. Mary's bowlers hardly had time to loosen their arms.

ST. BARTHOLOMEW'S HOSPITAL v. BLACKHEATH.

Played at Winchmore Hill on July 7th.
Scores: Blackheath, 162 for 8 declared.
Bowling: Anderson, 3 for 29; Mundy, 3 for 56.

R. M. Kirkwood, c Cockhart, b McAllen	30	J. D. Wilson, c J. C. Cochrane	} Did not bat.
R. C. Dolly, b Cart-Archer	13	C. G. Nicholson	
C. R. Morison, b Banham	4	D. J. A. Brown	
G. D. Wedd, not out	90	C. M. Dransfield	
R. Mundy, b Banham	19	Extras	
J. D. Anderson, c Allen, b Cart-Archer	34	Total (5 wkts.)	

Blackheath won the toss and batted first on a perfect wicket. They were rather slow in getting runs, and after 24 hours declared for 162, leaving Bart's two hours to make this number. This they managed to do with a quarter of an hour still in hand, and finished with 205 for 5. Wedd hit lustily for his 90 not out, including 12 fours.

ST. BARTHOLOMEW'S HOSPITAL v. SHOEBOURNNESS.

Played at Shoeboourness on July 14th. Lost by 3 wickets.
Scores: Shoeboourness Garrison, 255 for 5 wickets.

R. M. Kirkwood, c McEvoy, b Morris	77	W. M. Maidlow, c McLeod, b Gibson	31
R. C. Dolly, c Parkinson, b Gibson	3	I. N. Fulton, run out	9
C. R. Morison, c and b Rosseler	36	R. McEwen, c and b McEvoy	0
C. M. Dransfield, b Harrap	76	E. O. Evans, not out	6
R. Mundy, c McEvoy, b Morris	4	J. R. Simpson, b McEvoy	0
		J. G. Berry, b McEvoy	0
		Extras	9
		Total	251

Bart's opened on a perfect wicket amidst perfect surroundings. Kirkwood hit any loose balls hard from the start, and added another 70 to his many this season. Dransfield also played good cricket, and with Morison and Maidlow collecting a few runs, the respectable total of 251 was made in 24 hours. Shoeboourness were left not quite so long, and played forceful and attractive cricket to pass this total with three minutes to spare. For the last few minutes of the game it rained rather heavily, and prevented the bowlers from having any chance with the slipping ball. Fulton kept wicket excellently, and his three stumps were all opportunely taken.

ST. BARTHOLOMEW'S HOSPITAL v. TIMES C.C.

Played at Ravensbourne on June 20th. Match drawn.
Scores: Times C.C., 148 for 8 wickets.
Bowling: Morison 3 for 20; Nicholson, 3 for 32.

R. M. Kirkwood, b Hinchliff	72	C. G. Nicholson, b Blanchard	22
R. C. Dolly, b Hurton	17	J. D. Anderson, c Daniels, b Blanchard	0
C. R. Morison, run out	6	I. C. Newbold, b Carter	7
D. J. A. Brown, st Burnaze, b Carter	6	W. R. Grant, not out	3
W. M. Capper, c and b Carter	0	Extras	10
R. Mundy, b Blanchard	53		
J. D. Wilson, b Carter	35	Total	237

Kirkwood and Dolly saw the 50 on the board before the latter was out, after which Kirkwood got little support until he was joined by Mundy, when the score started to mount rapidly. Kirkwood was out at 191, having made a useful 72. Mundy, joined by Wilson, scored at a great rate, and his 50 was one of the best innings this year. After a good first-wicket partnership the Times fared badly, and had only a draw to play for. Morison, in the last over of the match, took 3 wickets in 4 balls.

SWIMMING CLUB.

United Hospitals Water-Polo Semi-Final.

ST. BARTHOLOMEW'S HOSPITAL v. ST. MARY'S HOSPITAL.

Played at St. Mary's Hospital, June 25th, 1934. Result: Bart's 11, St. Mary's 1.

Mary's opened the scoring by a swim through from half-way, followed by a quick throw-in. After this Bart's appeared to take complete possession of the game, and from then onwards never appeared to be in a dangerous position. At half-time, as a result of a series of passing movements and quick shooting, the score was 7-1, goals having been scored by McKane, Newbold, Sutton and Vartan. During the second half four more goals were scored by Newbold, Sutton and Vartan. Bart's combined very well as a team throughout the game.

Team.—C. M. Dransfield, G. S. Vartan, B. H. Goodrich, R. J. C. Sutton, T. O. McKane, J. C. Newbold, C. K. Vartan.

United Hospitals Swimming Gala.

The fourteenth Annual Gala of the United Hospitals' Swimming Club was again held at Marshall Street Baths on June 30th, and was well supported. The evening provided some exciting races, which

were interposed by an excellent display of acrobatic diving by the Highgate Diving Club, and an exhibition of fancy swimming by Miss E. V. Davies, of Cardiff. The last event of the evening proved more exciting than usual when Bart's met Guy's in the final of the Inter-Hospitals Water Polo, which Bart's again won for the sixth year in succession; similarly Bart's won the swimming and the diving for the fifth and second years in succession respectively. We should like to offer our hearty congratulations to J. C. Newbold and R. J. C. Sutton on their magnificent performances throughout a very strenuous evening.

United Hospitals Water Polo Final.

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

Played at Marshall Street Baths, June 30th. Result: Bart's 3, Guy's 2.

This was by far the best match of the season, and though there was close marking accompanied by some of the questionable tactics which always occur in the final, the play was of quite a high standard and most exciting for the spectator.

Vartan opened the scoring for Bart's after a pass from Newbold, who swam through from behind, half-way. Play then remained even until Bart's got possession of the ball, and after some clever passing Vartan scored again the score at half-time being Bart's 2, Guy's 0.

In the second half Bart's defended the deep end and Guy's pressed hard. Soon after half-time Sutton intercepted a pass and swam through to pass to Newbold, who scored in the right-hand corner. Guy's then scored two goals in fairly rapid succession, and the game ended without further scoring in a close victory for Bart's. Dransfield played a sound game in goal.

Team.—C. M. Dransfield, G. S. Vartan, P. Quibell, R. J. C. Sutton, T. O. McKane, J. C. Newbold, C. K. Vartan.

RIFLE CLUB.

The season on the open range was brought to an end with the United Hospitals Challenge Cup match at Bisleys on Monday, July 16th.

Unfortunately it cannot be said to have been a very successful one, both the Armitage Cup and the United Hospitals Challenge Cup having found homes far removed from Bart's. However, there are other seasons to come, and it is hoped that the end of a not too distant one will find one or other of these "pots" once more sitting in the Library.

Congratulations are offered to St. Mary's team in general for the excellent score with which they won the Challenge Cup, and to R. J. C. Hutchinson in particular for his score of 104 out of a possible 105—a record performance.

Armitage Cup Result.

Won by Guy's	Score	2238
2nd, St. Mary's		2223
3rd, St. Bart's		2216
4th, The London		2212
5th, St. Thomas's		2162

St. Bart's Final Stage Scores.

B. P. Armstrong	96
J. E. Underwood	94
J. Dalziel	92
B. C. Nicholson	91
K. F. Stephens	87
H. Bevan-Jones	77

At the United Hospitals Prize Meeting the following prizes were won by members of Bart's team:

	Score.	Possible.
500 yards. Tied 1st prize, B. C. Nicholson	34	35
600 " 1st prize, J. E. Underwood	33	35

The Benefic Cup, for the highest aggregate of all scores made by a member of St. Bart's team in the Armitage Cup Competition, was won by J. Dalziel with a score of 387 out of a possible 420.

United Hospital's Challenge Cup Result.

Won by St. Mary's	Score	480
2nd, Guy's		481
3rd, St. Thomas's		460
4th, St. Bart's		456
5th, The London		427
Highest possible score,		525.

St. Bart's.

J. Dalziel	98
K. F. Stephens	93
B. P. Armstrong	91
B. C. Nicholson	87
J. E. Underwood	87

J. D.

ATHLETIC CLUB.

THE ANNUAL SPORTS.

This meeting was held at Winchmore Hill on June 30th, in brilliant sunshine. This last fact is notable, because for many years past the function has been spoilt by rain.

The meeting was further notable for several good performances. Two records were broken: Dransfield threw the javelin 143 ft. 10 in. to beat his previous record by 10 ft.; second and third in this event also beat the previous record by a few inches. Records were equalled by Nel in the 100 yds., and Youngman in the 120 yds. hurdles. After the meeting the prizes were distributed by Mrs. Kettle.

RESULTS.

- 100 Yards: 1, J. G. Nel; 2, J. G. Youngman. Won by 1 yard. Time, 10½ sec.
- 220 Yards: 1, J. G. Nel; 2, W. H. Jopling. Won by inches. Time, 23½ sec.
- 440 Yards: 1, W. H. Jopling; 2, J. G. Nel. Won easily. 53½ sec.
- 880 Yards Handicap: 1, G. T. S. Williams (10 yards); 2, N. J. P. Hewlings (30 yards). Won by 5 yards. Time, 2 min. 8 sec.
- 120 Yards Handicap: 1, G. Herbert (5 yards); 2, G. Gray (10 yards). Won by inches. Time, 1½ sec.
- 1 Mile: 1, G. T. S. Williams; 2, N. J. P. Hewlings. Time, 4 min. 45 sec.
- 3 Miles: 1, N. J. P. Hewlings; 2, H. B. Lee. Time, 17 min. 20 sec.
- Throwing the Javelin: 1, C. M. Dransfield, 143 ft. 10 in. (record); 2, E. E. Harris, 139 ft. 10 in.
- Putting the Weight: 1, G. D. Wedd, 36 ft. 11 in. (record); 2, G. Gray.
- High Jump: 1, G. L. Way, 5 ft. 4 in.; 2, G. H. Fairlie-Clarke, 5 ft. 2 in.
- 120 Yards High Hurdles: 1, J. G. Youngman; 2, G. L. Way. Won by 1 yard. Time, 17½ sec.
- Long Jump: 1, J. G. Youngman, 20 ft. 1½ in.; 2, J. G. Nel.
- Pole Vault: 1, C. M. Dransfield, 8 ft.; 2, J. G. Nel, 7 ft.
- Inter-Club Relay: 1, Rugger 1st XV; 2, Rugger "A" XV; 3, Veterans.

CORRESPONDENCE.

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

DEAR MR. EDITOR,—I wish to express through you my grateful thanks to those Fellows of the Royal College of Surgeons who assisted me in my election to the Council. I very much appreciate the loyal support that they have given to me, and trust that my efforts on the Council will be such as to deserve it.

Yours sincerely,

Mullion, W. GIRLING BALL.
July 14th, 1934.

REVIEW.

BRIGHT'S DISEASE. By J. NORMAN CRUICKSHANK, M.C., M.D., D.Sc., F.R.F.P.S.(Glas.), M.R.C.P.(Lond.). (Edinburgh: E. & S. Livingstone, 1933.) Pp. 208.

The author's object in writing this book is to provide the practitioner and the senior student with a short account of the clinical application of the modern views of the nature of Bright's disease, and only those who realize the difficulty of this task will fully appreciate the success with which it is achieved.

The text is divided into ten chapters, the first of which contains a useful summary of the principal theories of normal kidney function, subsequent chapters being devoted to the classification, description and aetiology of the inflammatory, degenerative and vascular types of Bright's disease. Tests of renal function, oedema and uræmia are dealt with in separate chapters, and an appendix is added which contains notes on the structure of the kidney, the classification of Bright's disease, and methods of estimating renal functional sufficiency.

The general arrangement is good, but might, I think, be improved by placing the notes on the structure of the kidney in the first chapter before the account of kidney function. The classification employed errs on the side of simplicity but is not unconventional, while an ingenious diagrammatic representation is given of the mixed types of nephritis. Focal nephritis is briefly considered, but many will disagree with the author when he says that in the embolic form uræmia does not occur.

The chapter on the vascular types of Bright's disease is perhaps the least successful, and the views put forward on the relationship between the various sub-types open to criticism.

In the treatment of Bright's disease the only serious omission is the use of intravenous glucose solution as a diuretic, which is of value in certain cases.

The various tests for renal function are described and criticized, but it is unfortunate that the urea concentration test is accepted as the standard of nitrogen excreting function in favour of the urea clearance which the author allows is probably the better test.

The final chapters on oedema and uræmia should greatly assist students in understanding these subjects, and stimulate their interest in them.

Short bibliographies at the end of each chapter add greatly to the value of a book for which there is a great need, and for which there should be a great demand.

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

ADRIAN, E. D., M.D., D.Sc., F.R.S., F.R.C.P. *The Mechanism of Nervous Action: Electrical Studies of the Neurone*. Philadelphia: University of Pennsylvania Press, 1932.

ANDREWES, C. H., M.D. "Vaccines in Relation to the Aetiology of Tumours." *Lancet*, July 14th, 1934.

BETT, W. R., M.R.C.S., L.R.C.P. "Some Pædiatric Eponyms: V. Young's Rule." *British Journal of Children's Diseases*, April-June, 1934.

BURKE, C. T., M.D., F.R.C.P., I.M.S. (and GUPTA, S. P., M.D.). "Dry Pleurisy with High Eosinophil Leucocytosis." *British Medical Journal*, July 7th, 1934.

FEILING, ANTHONY, M.D., F.R.C.P. "Hemiplegia." *Practitioner*, July, 1934.

HALL, ARTHUR J., M.A., M.D., D.Sc.(Hon.), F.R.C.P. "The Prognosis and Treatment of Chronic Epidemic Encephalitis." *Practitioner*, July, 1934.

MYERS, CHARLES S., C.B.E., F.R.S. *A Psychologist's Point of View: Twelve Semi-popular Addresses on Various Subjects*. London: William Heinemann, Ltd., 1933.

ROSS, J. PATERSON, M.S., F.R.C.S. "Prognosis of Raynaud's Disease." *Lancet*, July 14th, 1934.

VINES, H. W. C., M.A., M.D. *Green's Manual of Pathology*, 15th edition. London: Baillière, Tindall & Cox, 1934.

CHANGES OF ADDRESS.

BENTON, D., 375, Mitcham Road, West Croydon.

MORGAN, E. W., 3, Loughborough Park, S.W. 9.

REES, T. P., Cornegar, Waulingham, Surrey.

REYNOLDS, J. B. A., 2, Highfield Crescent, Southampton.

STARKEY, Wing Comdr. H. S. CRICHTON, O.B.E., R.A.F.M.S., Everydens, Lindfield, Sussex. (Tel. Lindfield 146).

WATKINS, D. J. G., "Oakcot", Holly Lane, Four Oaks, near Birmingham.

WILMOT, Col. R. C., R.A.M.C., Minsterville, The Leas, Minster, Sheerness, Kent.

APPOINTMENTS.

BURROWS, H. J., M.B., D.Chir.(Cantab.), F.R.C.S., appointed Hon. Orthopaedic Surgeon to the National Hospital, Queen Square.

CASTLEDEN, L. I. M., M.D.(Lond.), appointed Honorary Medical Registrar to the Royal Sussex County Hospital, Brighton.

SPARKS, J. V., D.M.R.E.(Cantab.), appointed Hon. Radiologist to the King Edward VII Sanatorium, Midhurst.

BIRTHS.

STRUGNELL.—On July 16th, 1934, at Royal Marine Barracks, Plymouth, to Edythe, wife of Surgeon-Commander L. F. Strugnell, R.N.—a son.

WILLIAMS.—On June 7th, 1934, at Hazelwood, Nailsworth, Glos, to Mary, wife of Dr. R. N. Williams—a son.

MARRIAGE.

EVANS—HENDERSON.—On July 17th, 1934, at the Church of St. John the Evangelist, Edinburgh, Evan Stanley Evans, to Muriel Gordon Henderson, F.R.C.S.E.

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: National 4444.

St. Bartholomew's Hospital



JOURNAL.

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

VOL. XLI.—No. 12.]

SEPTEMBER 1ST, 1934.

PRICE NINEPENCE.

CALENDAR.

Tues., Sept. 4.	—Prof. Fraser and Prof. Gask on duty.
Fri., " 7.	—Lord Horder and Sir Charles Gordon-Watson on duty.
Tues., " 11.	—Dr. Hinds Howell and Mr. Harold Wilson on duty.
Fri., " 14.	—Dr. Gow and Mr. Girling Ball on duty.
Tues., " 18.	—Dr. Graham and Mr. Roberts on duty.
Thurs., " 20.	—Last day for receiving matter for the October issue of the Journal.
Fri., " 21.	—Prof. Fraser and Prof. Gask on duty.
Tues., " 25.	—Lord Horder and Sir Charles Gordon-Watson on duty.
Fri., " 28.	—Dr. Hinds Howell and Mr. Harold Wilson on duty.
Sat., " 29.	—Rugby Match v. Old Leysians. Home.

EDITORIAL.

THE incidence of a holiday makes the preparation of a suitable preamble for the last Journal of the Hospital year an unwelcome task. The sea and the mountains and the thunder of a tent flapping in the gale are unhappy henchmen of the Muse when the mind seeks to turn back to Hospital business and politics.

An effort to test the proverb, "the night is the mither of thoughts", only resulted in a shamefaced and violent reveille in the short hours, the manuscript covered by the cold corpse of a dead candle.

* * *

It was once the custom to include in the September issue a retrospect of the past year's events. Latterly the duty has been usurped by the Editor on account of the barrenness of the month that is gone. *Il n'y a point de dimanches et de fêtes en l'aout*, and he must needs manufacture a topic for a quite unnecessary paragraph. We, however, derive no pleasure from the resurrection of events in a year more or less uneventful in the Hospital's history and, in any case, it is tedious to physic the dead. Even had the wish been present, circumstances would have prohibited, for here there are no past numbers to instruct us and no diaries to be brought into use, for we agree heartily with Mark Twain that "only those rare natures that are made up of pluck, endurance, devotion to duty for duty's sake, and invincible determination, may hope to venture upon so tremendous an enterprise as the keeping of a journal and not sustain a shameful defeat". We leave the past year to join the others, close Volume Forty-one of the Journal and call *Salve!* to the next.

* * *

The successive heat-waves have exposed the deficiencies in the cooling apparatus of the new surgical wards. Even the skill of Sister in moving her single fan in the orbit of the Senior Surgeon on a hot full-day has availed nothing. Waring Ward has been equipped temporarily with three huge fans suspended from the roof in one half of the ward. Hideous at present with their gallows-like supports, they would never be anything but unsightly even if their value was proved.

The failure of the weather to exhibit pyrexia since their installation has made a true test difficult, but opinion seems agreed that they are unsuitable. Their effect has been to produce a wintry gale and a chorus of protests from the patients.

It seems odd that in a period of exceptional drought a long-wanted protection from the rain should have been devised for the comfort of the out-patient queues.

In the Giltspur Street entrance to the Hospital a glass covering has been constructed round three sides of the court. We hope to see some similar solution for those unfortunates that have to be trundled across the Square in a downpour on their way to the specialist departments. At present an expensive subway seems to be the only elegant method.

* * *

Prof. Langdon Brown, Regius Professor of Physic at the University of Cambridge, has been appointed Senior Censor of the Examining Board by the Royal College of Physicians.

* * *

The same body has also appointed Sir Henry Hallett Dale, C.B.E., as the Harveian Orator for 1935, and Sir Bernard Spilisbury as Croonian Lecturer for 1936.

* * *

It is with a great shock that we hear, as we go to press, of the tragic death of T. H. Moxon. He was spending his holidays at Wimereux when he was drowned while bathing.

He was born on October 22nd, 1908, and was educated at Berkhamsted School. He entered St. Bartholomew's in January, 1931, and very soon interested himself in the affairs of the Hospital. The most uninteresting and thankless tasks were undertaken by him in the calm, cheerful spirit that was always characteristic of him. He was one of those the loss of whom means a great deal to any community.

Our sincere sympathy is extended to his bereaved.

* * *

Much progress has been made in the new buildings for the University of London at Bloomsbury. The site occupies over ten acres behind the British Museum. The part at present under construction will accommodate the Senate House, the Library, the Administrative Block and the Institute of Education. These will cover about two-fifths of the site and will be completed within four years.

* * *

OBITUARY.

P. W. JAMES, M.C., M.D.

ALL ranks of the 2nd Battalion of the Seaforth Highlanders who served in the South African War, and all who served in the same battalion in the Great War, will have heard with deep regret the death of Dr. P. W. James, of Friends' Road, Croydon.

"Jimmy," as he was affectionately known, had the splendid, if not unique, record of having served as medical officer to the same battalion, on active service, in two wars, although a doctor in private practice. That battalion was the 2nd Seaforth Highlanders, and no unit was ever more fortunate in their medical officer, or in more skilful and devoted hands. After serving through the South African War he returned to private work, but at the outbreak of the Great War he immediately offered his services again, and applied to return to the regiment he knew so well. His wish was fulfilled, and he rejoined as Medical Officer to the 2nd Battalion on the Aisne in September, 1914. He carried out his duties with the utmost gallantry and devotion to duty, which earned him not only a very richly deserved M.C., but the deep affection of both officers and men. He was always the same—undaunted, calm and cheerful under the most trying conditions imaginable.

In the first German gas attack in the spring of 1915 he was very severely gassed, from the effects of which he never recovered. He returned to private practice, but in later years his health grew steadily worse. The event of the year he looked forward to more than anything else was attending the Regimental Dinner of the Seaforth Highlanders. This year he was too ill to attend, and within a month he was dead.

He was laid to rest in Shirley Churchyard near Croydon on July 10th, while a piper of the Seaforth Highlanders played "The Flowers of the Forest" beside his grave, in affectionate farewell.

A SEAFORTH OFFICER

THE CONGENITAL SHORT ŒSOPHAGUS.

"The stomach is originally almost cervical in situation; but as the pleural diverticula expand and the diaphragm descends, the œsophagus becomes elongated, and thus the stomach also descends, maintaining all the way a sub-diaphragmatic position. If, however, the œsophagus does not elongate, the descent of the stomach is arrested, and thus we find it placed within the posterior mediastinum surrounded by its sac of peritoneum."—[Keith (1)].

FAILURE of the œsophagus to grow to its proper length has been recognized by anatomists for nearly 100 years, but it does not seem to have occurred to them that either the short œsophagus, or the abnormality of the stomach which is of necessity associated with it, could be matters of clinical importance. Recently, however, clinicians have realized that such a short œsophagus may be abnormal in function as well as in structure; and that symptoms may be produced by the distension of the portion of the stomach which has never descended below the diaphragm, and by the entry of abdominal viscera into the peritoneal sac which is almost always present around the thoracic portion of the stomach—a form of diaphragmatic hernia.

Rarely the œsophagus is extremely short, but in most cases it ends at a level between the sixth and eighth dorsal vertebrae. Here the tube is considerably narrowed, and then widens out again before reaching the diaphragm. This wider portion, though at first sight appearing to be the lower end of the œsophagus, is in reality a portion of the cardiac end of the stomach. More careful study even by the naked eye will establish the difference in colour, texture and folding of the mucous membrane above and below the narrowed portion, and histologically the mucous membrane below the narrowing but above the diaphragm is found to be gastric.

A married woman, *et. 64*, was admitted to Lawrence Ward on July 16th, 1934, because of inability to swallow. She had been warded on the Medical Side in March, 1934, when a tentative diagnosis of carcinoma of the œsophagus was made, and a course of deep X-ray therapy was given. X-ray examination in March had revealed an obstruction in the œsophagus at the level of the eighth dorsal vertebra (Fig. 1), but the œsophageal lumen above the constriction appeared quite regular and smooth, and was not much dilated, and it was therefore suggested that the obstruction might be due to spasm. Œsophagoscopy failed to provide evidence of carcinoma, and the Wassermann reaction was negative.

On July 16th a mouthful of barium emulsion was completely arrested at the stricture, though the œsophageal wall above still showed no indication that the obstruction was due to malignant disease. Gastrostomy was performed at once, an unusual feature being the low position of the stomach in the abdominal cavity. Three days later she was able to swallow a little water, and a week after the operation she was able to take about a pint of fluid daily by the mouth. This quantity was subsequently steadily increased, till it became possible to repeat the barium X-ray examination.

Fuller inquiry into her past history elicited the fact that she had suffered from periodical "bilious attacks" since childhood. These

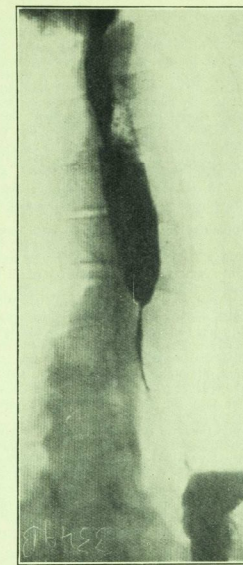


FIG. 1.—SHOWING OBSTRUCTION TO BARIUM AT LEVEL OF EIGHTH DORSAL VERTEBRA—MARCH, 1934.



FIG. 2.—SRIAGRAM TAKEN WITH PATIENT IN TRENDLENBURG POSITION, SHOWING BARIUM WHICH HAS REGURGITATED INTO A POUCH OF STOMACH ABOVE THE DIAPHRAGM—AUGUST, 1934.

attacks, which occurred at intervals of a few months, started with pain in the epigastrium immediately after a meal, the pain being relieved by vomiting bitter fluid. Until the attack passed off she would be unable to keep any fluid down, and in a few of the worst attacks she felt she could not "get down" even water, and had to stay in bed for several days until the attack gradually passed off. When 35 years of age she had been kept in bed for three weeks by "gastric" trouble. Heartburn was a prominent feature, but she did not complain of flatulence. For the past few years she had become increasingly breathless on exertion, though there was no pain in the chest. Cough had been troublesome for many years, especially at night, and if coughing induced vomiting or if she made herself sick the cough ceased. All the symptoms had been greatly aggravated during the past six to twelve months, and she had lost 3 stones in weight.

The X-ray examination of the œsophagus was repeated by Dr. Dudley Stone on August 9th. With the patient standing, thin barium emulsion was seen to pass down to the stricture, which seemed to be about 2 mm. in diameter and 4 mm. in length, a fine stream of barium trickling through it into a wider portion of the alimentary canal between it and the diaphragm. When sufficient barium had reached the stomach, the patient was placed lying on the table, inclined so as to raise the level of the abdomen above the chest, and the barium was seen to flow back into the tube above the diaphragm as far as the lower end of the stricture (Fig. 2). This showed clearly that although there was a second narrowing in the barium shadow at the level of the diaphragm, there was no sphincter at this point, but that the tube between the stricture and the diaphragm was part of the stomach.

The obstruction at the level of the eighth dorsal vertebra was thus shown to be a stricture at the lower end of a congenital short œsophagus, and it was also clear that the stomach was greatly narrowed where it passed through the diaphragm. Dysphagia was caused by the constriction at the lower end of the œsophagus, but the epigastric pain may have been due to distension of the portion of the stomach above the diaphragm. The fact that pain was relieved by vomiting bitter material harmonizes with this view.

SYMPTOMS OF THE SHORT ŒSOPHAGUS.

There seems to be no doubt that this developmental defect may exist throughout life without producing symptoms, for it has been discovered accidentally in the dissecting-room in the bodies of men well over the age of 70, whose history aroused no suspicion that there had been anything amiss.

On the other hand symptoms may be present from birth, and there is a third group in which symptoms appear intermittently at intervals of many years, becoming really troublesome only in middle age. Cases occurring in infancy and childhood have been published with complete X-ray studies by Findlay and Brown-Kelly (2); and a very interesting case in which there was no peritoneal coat over the thoracic portion of the stomach has been published by Jacob, Tweedie and Negus (3).

Vomiting is the most prominent symptom, especially in infants and children. It may be present from birth, thus differing from the vomiting of pyloric stenosis, and a characteristic feature is that it often occurs during a meal. Vomiting is often variable both in frequency and quantity, and may disappear for long intervals, even as long as five years elapsing between attacks.

Dysphagia occurs in sudden attacks with long intervals of freedom, and such a history in adult life distinguishes

this condition clearly from cancer. As a rule more difficulty is experienced in swallowing solid food, though it rarely happens that solids may be more easily swallowed than fluids.

Discomfort after food.—It is rare for patients to complain of severe pain, but discomfort immediately after swallowing food is almost always present, and is worse during the "attacks" of dysphagia. A remarkable feature is the different regions to which the pain may be referred, the pain being either "in the pit of the stomach", behind the sternum, below the angle of the left scapula, or below the left costal margin. The discomfort may be associated with flatulence and may be relieved by eructation of gas, thus mimicking the dyspepsia of cholecystitis.

Respiratory symptoms.—In adult life the condition is often associated with respiratory and cardiac symptoms. The most troublesome respiratory complication is spasmodic cough, rather like whooping-cough, produced by taking a meal and relieved by regurgitation of food or gas. The patient may even induce vomiting to obtain relief. Hiccough and "asthma" are often severe and may interfere with sleep.

Cardiac symptoms.—Pain simulating angina pectoris has been encountered (4). A feeling of "oppression" in the chest, unconsciousness following fits of coughing and dyspnoea due apparently to embarrassment of the heart has been observed in adults.

DIAGNOSIS.

A single X-ray examination made as the patient swallows a mouthful of barium emulsion may show either a complete stoppage between the level of the root of the lung and the diaphragm, or a stricture which in adults is commonly mistaken for malignant disease. The fact that the stricture is not at the level where carcinoma commonly occurs should make one suspect an error in this diagnosis. If the obstruction is incomplete the barium can be seen to enter a much wider portion of the tube below the stricture. This dilated portion above the diaphragm is quite unlike the lower end of the œsophagus below a stricture, being not only wide, but also rugose. Though there is a second narrowing where the tube passes through the diaphragm, this is not due to the cardiac sphincter, because if, when there is barium in the stomach, the patient be tilted up into the Trendelenburg position, the opaque material can be observed to flow freely back above the diaphragm as far as the stricture in the œsophagus. This provides the radiographic evidence that the tube between the stricture and the diaphragm is a portion of the stomach lying in the thorax.

That the dilated portion between the stricture and the diaphragm is in fact a portion of the stomach can be proved by passing an œsophagoscope and removing a fragment of mucous membrane from below the stricture. Sections of this fragment will show the usual arrangement of glands found in the cardiac portion of the stomach.

CAUSES OF THE SYMPTOMS.

(i) *The defect in the œsophagus.*—If the œsophagus were merely short there would be no reason for the obstruction which is present at the junction of the short œsophagus and the thoracic portion of the stomach. It has been mentioned already that this condition can exist without obstruction, but, as far as we can judge at present, a short œsophagus is very liable to obstruction at its lower end. It is questionable whether the obstruction is due to a defect of structure or of function at this point.

In support of a purely anatomical defect may be adduced the fact that the œsophagus is maldeveloped, and that in this same situation septum formation has been observed. Abel (5) had recorded a case in every respect similar to those now under consideration, except that a complete membrane closed the lumen of the œsophagus about 1 in. below the bifurcation of the trachea. The membrane was so thin that it was possible to rupture it by pressure with the œsophagoscope. Stricture formation might be regarded as a manifestation of the remnant of such a membrane.

Negus (3) has examined the œsophagus of a child of 1 year and 7 months who died after œsophagoscopy, and he found that at the site of constriction the mucous membrane was deficient and was replaced by granulation-tissue. This could not have been due to instrumentation, and it suggests that an inflammatory fibrous stricture may supervene as a complicating factor in at least some of the cases.

There are certain features, however, which are hard to explain on an anatomical hypothesis alone. The fact that the obstruction may not appear till young adult life, and that at all times of life it is present only from time to time, is more suggestive of a defect in the neuro-muscular mechanism governing the sphincter at the lower end of the œsophagus—a condition closely allied to if not identical with cardiospasm. It is not unreasonable to suppose that the lower end of the œsophagus when anatomically defective might show a disorder of function.

A patient under the care of the Surgical Professorial Unit at St. Bartholomew's Hospital (Sir Thos. Dunhill, Arris and Gale Lecture, 1934) had her first attack of dysphagia during her first pregnancy, and subsequent

attacks occurred during every pregnancy as well as at other times. In Abel's case, previously quoted, the infant also suffered from hypertrophic stenosis of the pylorus. Though these observations are brought forward merely as circumstantial evidence, they may be taken to suggest an association of this condition with sphincter disturbances in other viscera, the inference being that the œsophageal obstruction may itself be due to a disordered sphincter.

(ii) *The presence of part of the stomach in the thorax.*—Narrowing of the lumen at the lower end of the short œsophagus can account for dysphagia and retrosternal discomfort. But the respiratory and cardiac symptoms and the discomfort referred to the left subcostal and subscapular region are attributable to distension of the intrathoracic portion of the stomach. Occasionally these symptoms may be intensified as a result of herniation of other abdominal viscera through the œsophageal orifice in the diaphragm.

It must be understood that because the œsophagus fails to elongate and part of the stomach is anchored by it, the hernial sac is formed by the diaphragm moving downwards during development, and drawing a sac over the stationary stomach. The œsophageal orifice in the diaphragm is thus also maldeveloped, and may vary very considerably in size. It is never wide enough to allow the stomach to pass through easily, and as a rule it is so narrow that it produces an hour-glass constriction of the stomach.

Distension of the supra-diaphragmatic pouch of the stomach after a meal is probably the cause not only of pain, but also of the respiratory and cardiac symptoms which are so prominent a feature in adult cases, and relief of the symptoms by vomiting or eructation of gas is readily explained.

TREATMENT.

In infants improvement in swallowing has followed œsophagoscopy (2, 6), and if there is anything in the theory that the obstruction resembles cardiospasm, dilatation by bougies is the treatment which should be given a fair trial before resorting to other methods.

Should dilatation fail and should the symptoms be severe enough to demand treatment, trans-thoracic œsophago-gastrostomy would appear to be the rational procedure. Technical difficulty may arise owing to the proximity of important structures in the posterior mediastinum, and it may be impossible to free the œsophagus sufficiently to permit of carrying out the anastomosis if the lesion lies close below the root of the lung.

When symptoms are due to diaphragmatic hernia or

distension of the portion of the stomach which lies above the diaphragm, it will be necessary to alter the relationship of the stomach and diaphragm so that the diaphragm may be attached to the œsophagus at its lower end, and so that the stomach may lie entirely in the abdomen.

The following points in technique require consideration. As a preliminary measure the diaphragm should be paralysed by avulsion of the left phrenic nerve. This makes subsequent suturing of the diaphragm easier because the diaphragm is immobile, and lies at a higher level. But it occasionally does more than this, for the immobilization and raising of the diaphragm may prove to be in itself a sufficient therapeutic measure.

The best method of approach is probably a combination of the abdominal and thoracic routes. Since the œsophagus is short, even with a paralysed diaphragm it will be found difficult or impossible to excise the peritoneal sac, and to suture the diaphragm around the lower end of the œsophagus working entirely from the abdomen. With the chest open these steps may be completed more safely and more efficiently.

In removing the peritoneal sac and placing the stomach in the abdominal cavity, it may be found necessary to enlarge the opening in the diaphragm, and in the end there may be a large gap to fill in around the œsophagus. Fascial sutures may be of much help in achieving a sound closure, and fascial strips may be obtained either from the fascia lata or from the semi-spinales muscles (Lake (4)).

I am indebted to my House Surgeon, Mr. G. Weddell, for the reproductions of the radiograms.

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- (5) ABEL, A. L.—(*Œsophageal Obstruction* (Lond.), 1929, p. 54.
- (6) TUMARKIN, A.—*Journ. Laryngol. and Otol.*, 1933, xlviii, p. 489.

J. PATERSON ROSS.

SOME COMMON FRACTURES OF THE UPPER EXTREMITY.*

IT is impossible to consider more than a few fractures in the time at our disposal, and this would seem to be best employed in discussing those which are at the same time of common occurrence and do not require any complicated apparatus.

A supra-condylar fracture at the lower end of the humerus often occurs. It is usually seen in children. The fracture in the typical cases occurs, more or less transversely, about half an inch proximal to the epiphysal line at the lower end of the humerus, so that the epiphysis is displaced with the distal fragment. The distal fragment is displaced backwards, and the pull of the triceps tends to maintain this displacement. In the less severe degrees of this fracture the displacement simply takes the form of angulation of the distal fragment backwards on the shaft, making a convexity forwards at the site of fracture. Such fractures are not difficult to treat. In the more severe degrees the distal fragment is completely separated from the shaft of the humerus and lies posterior to it. In these cases it is often found that the distal fragment is also displaced to one side in addition to its backward displacement—usually to the ulnar side. In cases of great severity paralysis of one or more nerves may be found; the musculo-spiral is most commonly involved, it being stretched over the anterior aspect of the prominent lower end of the shaft. It is obviously important to recognize any nerve lesion before any manipulative or other treatment is carried out, otherwise the doctor may be blamed for the paralysis.

There is hardly a fracture in the body to which the old teaching of immediate reduction of the fragments applies more strongly than to a supra-condylar fracture of the humerus in a child. In spite of considerable swelling, or any other difficulty, an immediate attempt at manipulative reduction should be carried out under a general anæsthetic. The longer it is left the more difficult does reduction become. In those cases in which the deformity is a simple angulation of the fragments, it may easily be corrected by gripping the lower part of the upper arm with both hands, the fingers pointing anteriorly and the thumbs being behind; with the latter, pressure is exerted in a forward direction over the back of the distal fragment and elbow-joint, and the displacement is corrected. In those cases where the distal fragment lies completely behind the lower end of the shaft the procedure is different. An assistant

* A lecture in the Post-Graduate Course given in St. Bartholomew's Hospital.

holds the upper arm firmly, while the surgeon with the elbow in the extended position makes firm traction on the limb by pulling on the wrist until shortening is overcome. While still maintaining this traction on the wrist with one hand the elbow is flexed, and at the same time the distal fragment is held away from the lower end of the humeral shaft by the surgeon grasping the proximal part of the forearm with his other hand. If reduction is satisfactory the fragments usually tend to remain in position. The arm is then immobilized with the elbow at a right angle by means of a plaster splint along the back of the arm and forearm. The forearm should be in a position of pronation. It seems hardly safe to put the arm in a position of full flexion immediately after reduction of the fracture, as has been advised. The latter position in the presence of swelling is likely to cause such pressure on the vessels at the elbow as to lead to Volkmann's ischæmic contracture. The arm is kept at complete rest at a right angle for ten to twelve days according to the amount of swelling; the plaster splint is then removed and the forearm is suspended from the neck by a collar and cuff. The latter is shortened from day to day so that the elbow is gradually flexed more and more. After three weeks gentle active movements are begun, but great care must be exercised lest the movements of full flexion be lost; for this reason it is wisest for the collar and cuff to be worn at night, and for most of the day until five weeks from the date of the accident, when full but careful use of the arm may be allowed.

Volkmann's ischæmic contracture has already been mentioned; although, fortunately, not very common, it is such a disaster when it does occur that I will refer to it again briefly. After reduction of any fracture in the region of the elbow in a child the circulation of the hand must be watched most carefully during the first three or four days. It is not sufficient to feel the pulse at the wrist, as venous obstruction will cause ischæmic contracture. Any cyanosis or venous dilation must be looked for, and if there is any suspicion of these being present, the elbow must be extended a little more until a healthy circulation is restored. All severe fractures of the elbow are best treated with the patient in bed, and the arm well elevated above the body—this diminishes swelling and thus allows a better circulation.

Sometimes it is impossible to obtain a perfect position by manipulation. A decision has then to be made as to whether one will be satisfied with this imperfect position, or whether an open operation should be carried out in an attempt to obtain a perfect reduction of the fragments. Every case has, of course, to be judged individually, but in children one should not be too keen to operate; if the position after manipulation is

moderately good, it is often wiser to continue with closed methods, as ultimately the function obtained will be as good, if not better than if an operation is performed. Operation is more frequently indicated in adults.

Colles's fracture is still the most common of all fractures seen at this Hospital. This fracture for some years was treated, after reduction on a padded splint, with early massage and movements. For the last five years we have followed the ancient principles of rest in the treatment of fractures, and using the technique advocated by Böhler have kept the wrist absolutely immobilized until the fracture has united.

Early reduction is extremely important in obtaining early return of function and avoiding stiffness. Until the fracture is reduced and securely immobilized the patient is not to move her fingers; and so, if her reduction is left until the day following the injury, 24 hours are lost in commencing active finger movements, which are so important in obtaining early and full function, not only of the fingers, but of the whole hand and wrist.

The patient being anæsthetized, the fracture is reduced. It cannot be emphasized too strongly that the first step in reducing a Colles's fracture is to make certain that the fragments are disimpacted before an attempt is made to bring the distal fragment forward into its correct position. Contrary to what is sometimes said, a certain number of Colles's fractures tend to slip out of position again after reduction if they are not securely held by a close-fitting splint. A dorsal plaster splint is therefore used. A plaster-of-paris bandage, 5 yds. long and 4 in. in width, is made into a slab by unrolling it backwards and forwards upon itself on a flat surface (preferably glass), after it has been soaked in cold water. It is made of a length sufficient to reach from just below the elbow to the heads of the metacarpals. While still quite wet and soft, it is placed on the back of the forearm and hand and carefully moulded to the shape of the limb, especially around the bony prominences at the wrist; the sharp corners of the plaster above and below are rounded off immediately, while they can still be cut easily with a strong pair of scissors. It is especially important to do this at the upper end, cutting away the plaster sufficiently, so that when the elbow is fully flexed the plaster will not press into the skin in front of the elbow. Before the plaster has set a 2½-in. calico bandage is put on firmly, but not tightly, around the forearm and hand; it is taken round the wrist and hand, coming across the heads of the metacarpals and through between the thumb and index finger; it is kept well up into the cleft between the latter two so that flexion of the index finger is quite unimpeded. While the plaster is

is setting, the wrist and forearm are firmly gripped by the surgeon with both hands, holding the fracture well reduced. When the plaster has set, in order to hold the hand more securely up to it, a turn of 1-in. adhesive strapping is put around the hand over the bandage, coming through between the thumb and head of the metacarpal of the index finger.

The position in which the hand is immobilized varies according to the severity of the case. If the fracture is one which, after reduction, remains in the corrected position well, or can easily be held in good position, then the hand and forearm are put in a straight line, *i. e.* the wrist is in a neutral position; the forearm is kept midway between pronation and supination. If there is a considerable tendency for the fragments to slip back into bad position after reduction, then the Cotton-Loder position of flexion at the wrist with ulnar deviation and pronation is used. The Cotton-Loder position is excellent for maintaining the distal fragment in a correct position, but it is not good for obtaining rapid return of function, therefore this position is kept only for a week; the plaster splint is then removed and replaced by a fresh one in a neutral position, as for a simple Colles's fracture. When using this method of a dorsal plaster unpadding splint the patient can flex her fingers fully into the palm—a thing she cannot do with some other splints, *e. g.* a Carr's splint. She is encouraged to move her fingers through a full range as soon as the effect of the anæsthetic has passed off, and is ordered to extend her elbow and raise her arm above her head several times a day. When an elderly person keeps his or her arm in a sling for some weeks, it is not uncommon to find considerable stiffness of the shoulder. Whatever the cause of this, it can easily be avoided by raising the arm above the head once or twice a day. After two or three days she is discouraged from using a sling, and urged to use her hand as much as possible for light duties. When the splint fits the limb exactly as a plaster splint does there is absolute immobility of the fragments, and thus absence of pain, when using the hand, after the first few days. When the hand and elbow can be used freely, extremely little stiffness occurs at the wrist. The plaster splint is kept on for four weeks or longer in the case of old people; three weeks is usually sufficient in young persons and in cases of separation of the distal radial epiphysis. The splint is not removed during this time, except in exceptional cases, when it gets loose; then it is replaced by another similar one. No massage or other form of physio- or electro-therapy is used other than the free use of the hand and elbow by the patient, except in the case of elderly patients after the removal of the plaster. It is surprising in what good condition the forearm and hand

are when the splint is removed, and what good movements are present immediately, or at any rate within 24 hours after removal of the splint. If a patient has light manual work, he is able to do it while the splint is still on. In one case a man returned to his work of driving a motor-van after 14 days; while another man, except for 2 days' absence from work, continued, without interruption, his employment as a tailor, though he said that with the splint in position it was not easy to do really fine stitching.

There are two other fractures I wish to discuss briefly. Though these two may not seem to be common they are really of not at all infrequent occurrence, and are particularly important because they may so easily be overlooked at first, unless the possibility of their occurrence is remembered and skiagrams are obtained. I refer to fracture of the head of the radius and fracture of the scaphoid (navicular) at the wrist.


Following a fall on the outstretched hand, or on the elbow, the patient complains of pain in the latter. There is no deformity nor, at first, swelling, and the case may be looked upon as a sprained elbow. Close examination may, however, reveal a localized tenderness over the head of the radius, and skiagrams show a vertical crack in the bone usually in the anterior half of the head. There is a variety of fractures of the head of the radius, but this vertical crack with little or no displacement is much the commonest, and indeed is one of the commonest fractures seen in the out-patient fracture clinic. It may be easily overlooked; indeed it is not very serious if it is, but it is always well, for more reasons than one, to know whether a patient has a fracture or not. When a vertical crack such as this is diagnosed, the elbow should be flexed to less than a right angle, and the wrist supported from the neck by a collar and cuff. It should be thus immobilized for about three weeks, after which the forearm may be dropped to a right angle for another week, when full movements may be carried out. It is sometimes advised that full movements should be allowed from the beginning, but in some of such cases there is a considerable and rather persistent stiffness from muscle spasm, though in others it is true that the case progresses very rapidly and well. In cases in which there is a definite displacement of a fragment, an attempt to replace it by flexing and extending the elbow while rotating the forearm may be attempted, but usually an open operation is required.

The only certain way to avoid missing a fracture of the carpal scaphoid is to have every injury of the wrist X-rayed, particularly if the pain and tenderness are on the radial side of the wrist. There is a variety of

fractures of the scaphoid, but the commonest is through the middle or waist of the bone. The wrist should be immobilized in a position of full hyperextension. Plaster-of-paris applied directly to the skin is the best splint. It should be left on for six weeks and then removed and the wrist X-rayed; if the fragments have not united (and union as early as this is very uncommon) it should be immobilized for another six weeks, and so on until there is union as shown in a skiagram. After eight months, immobilization may be stopped even though bony union is not present, as after this length of time, fibrous union so firm that it allows no movements of the fragments has usually occurred. Open operation with removal of a fragment or fragments is sometimes lightly suggested, but except in rare circumstances it is not advisable. Conservative treatment almost always gives a better result than operation—the most that can be said of operation is that it may improve a bad wrist following a fractured scaphoid, but it will never make a fair result into a perfect one. The result of a neglected fracture of the scaphoid is likely to be a stiff, weak and painful wrist.

JOHN HOSFORD.

SMALLPOX AND VACCINATION: A HETERODOX VIEW.

E who listen with credulity to the voice of authority, and follow with docility in the footsteps of Jenner; who expect that this age will reproduce the conditions of the past and Jenner's views be applicable to all the to-morrows; attend, I pray you, to the views of a heterodox pro-vaccinist.

I accept as a fact the statement that vaccination temporarily protects from smallpox, but I question the deduction of the orthodox that therefore everyone should be kept permanently immune from smallpox by repeated vaccination, and I deplore the official attitude of declining to subdivide the disease save in historic retrospect, and of even now failing to record the subdivisions statistically. Indeed, I consider it behoves the orthodox to reconsider their position, as there is such divergence between their views and what the generality will accept.

Immunization is a form of insurance, and there are two types of insurance, the one involving the paying of repeated premiums against a common or inevitable happening at an uncertain date, and the other the payment of a single premium against a happening during a limited period. Life insurance is an example of the former, insurance against war of the latter, and

the difference between the orthodox and the generality would seem to be that the orthodox consider smallpox infection to be a grave and continuing risk, while the community regard the infection as one to be guarded against only when it appears.

In 1933 the orthodox vaccinal faith was again reaffirmed by the Annual General Meeting of the British Medical Association; that meeting declined to admit that the substitution of voluntary for compulsory infant vaccination merited even consideration, and passed without a division a resolution, "That efficient vaccination and revaccination provide the only known method for the prevention of smallpox and its dissemination". This is pure Jennerism, undiluted by time or changed conditions.

When in 1798 Jenner published his discovery that milkmaids who contracted sores on their fingers from the udders of diseased cows were immune from smallpox, he at first thought this immunity of lifelong duration, and it was reasonable to advocate universal immunization by vaccination against a grave endemic disease from which few escaped. Again, because of the prevalence and gravity of smallpox it was natural to advocate revaccination when it was found that vaccinal immunity was not of lifelong duration. But in 1934 still to advocate general immunization requires explanation. It is true, however, that though we readily accept new ideas which do not conflict with old ones, we have great difficulty in admitting any error in established views. Lister's contemporaries, accustomed to the term "laudable pus", found the conception that pus was not laudable very difficult to accept; similarly for those brought up on the general vaccinal immunization faith, the idea that changed conditions may make such immunization both impossible and unnecessary is a difficult one even to consider, as Killick Millard, who has advocated the idea for more than twenty years, has found.

To state the orthodox view in practical terms: (1) Compulsory infant vaccination is, in fact, evadable, for if within four months of the birth the parent makes a statutory conscientious objection, the baby escapes vaccination; if it is not made, then, unless the baby be vaccinated within six-months, the parent is liable to a fine. In practice, however, only 40% of the babies born are vaccinated, and three out of five are not vaccinated. Of these vaccinated it is reasonable to suppose that half of them have orthodox parents who need no compulsion, if so, only one baby in every five is vaccinated compulsorily. Without regard, then, to the merits or otherwise of infant vaccination, it is surely arguable that since compulsion breeds resistance, voluntary vaccination and propaganda might result in the

vaccination of more babies, which is the goal of the orthodox.

(2) General immunization by vaccination and revaccination: What this means in practice for the individual is not precisely stated. In 1929 the vaccination committee reported that to immunize children they should be vaccinated in infancy, again at seven years of age, and a third time at fourteen; but they did not suggest what should happen after that. However, the Ministry of Health directs that applicants for work in smallpox hospitals be vaccinated unless they have been successfully vaccinated within the preceding two years; and according to this an applicant of seventeen would have to be vaccinated again even though he had already been vaccinated three times. In times of epidemic it is customary to advise inquirers that, unless they have been successfully vaccinated within the preceding five years, they are not safe from smallpox if exposed to infection. It is an interesting fact that the majority of orthodox doctors, if called upon to see a case of smallpox, promptly get vaccinated, for they do not trust themselves to have adequately carried out their own advice to maintain a state of permanent immunization. So unpractical is the advice that nowhere is it laid down what it means in practice.

How far is the general population immunized? 40% only of the babies are vaccinated, and this immunization is not to be relied on after seven years of age. Of those over seven years of age some of the orthodox are revaccinated, and financial pressure causes the vaccination of others, it being made a condition of employment in some cases, while it is common to make vaccination an antecedent condition of admission to convalescent homes of ailing children; also when smallpox infection is present in a locality many people are vaccinated. But the total of all these vaccinees in the whole population is so small that this country must be regarded as one unprotected by vaccination. In times of epidemic it is assumed that no one is protected by vaccination unless they can show that they are exceptions to this rule. With regard to infant vaccination, the majority of the local authorities who administer the vaccination laws have informed the Minister that in their opinion the compulsory element should be repealed and vaccination done free for those who desire it. To come now to the risk of smallpox, having outlined the orthodox method of protection against it.

THE SMALLPOX RISK.

In this country for a long period, the incidence of classical smallpox has been steadily diminishing, while

its virulence has remained substantially unchanged. The smallpox mortality per million of population per annum was:

For the period 1872-1880 . . .	156
„ „ 1881-1900 . . .	30
„ „ 1901-1910 . . .	13
„ „ 1911-1920 . . .	1

For the period 1921-1930 considerably less than 1, but there are no reliable official figures for this period.

Until 1919 in this country all smallpox was regarded as classical smallpox, or as it is now termed, "variola major". Then a mild form was introduced called in the Americas "alastrin" but now termed "variola minor", and there were more than 50,000 cases of it in the period 1921-1930. The two forms, variola major and minor, breed true, and their only difference is one of virulence. Obviously, then, they should be subdivided, but this has been done very imperfectly. The difficulty is that the laboratory people cannot differentiate between the two forms, and the clinician is accustomed to diagnose the individual case. A mild case of variola major may be indistinguishable from a case of variola minor, but if a consecutive series of six cases be considered the diagnosis is obvious. If the infection be variola major, one or more of the cases will be of a more virulent character than is ever seen in variola minor, and if there are no such virulent cases the infection is minor, and the epidemic will remain trivial in character; therefore local authorities should be able to say what the infection is in their areas. But the Registrar-General in his returns reports only smallpox, and does not subdivide the disease into its two forms, while the Ministry of Health did not until the autumn of 1933 state that in 1932 there were no cases of variola major, but some 2000 cases of variola minor. Furthermore, the Ministry of Health Report No. 62 of 1931, Smallpox Prevention, discusses the two forms, but gives no differential diagnosis.

As variola major is a disfiguring and often fatal disease, while variola minor does not permanently disfigure, and is of trivial character, save at the extremes of age, it is misleading not to subdivide them. Fortunately, however, variola major has news value, so the lay press emphasizes the difference between it and the prevalent variola minor. The Registrar-General, in addition to confusing the public by his undifferentiated smallpox, is by so doing led to make a misleading return of smallpox deaths. It is customary to regard the Registrar-General's statistical returns as exact statements of fact, whereas they are mere approximations.

The returns are derived from the death certificates

which state causes of death, from which the enumerator has to select one, using as his guide a manual in which is set out a list of causes in the order of their supposed gravity. The result is that from the certificate is selected the cause highest on the list. If smallpox appear on the certificate, smallpox must be the cause of death selected, for smallpox heads the Registrar-General's list, and being a notifiable disease, must be mentioned on the death certificate, however remote its influence on the fatal issue. To select variola major as the operative cause of death is substantially in accord with fact, but to select variola minor is of course to make nonsense of his return. Clearly therefore if smallpox were subdivided, variola minor would be placed very far down on this list.

During the period of variola minor prevalence there have been several introductions of variola major all rapidly brought under control; the risk of variola major infection continues to diminish, and is negligible. Since the public in the presence of variola minor largely refused vaccination, preferring to run the risk of the disease, the orthodox can hardly advocate their panacea—non-epidemic vaccination. Surely it would be better for the profession to reconsider their attitude, and devote themselves to further improving the eminently successful method of controlling infection when infection is present. The High Priests of orthodoxy, however, declare that, though variola major has been negligible for thirty years, yet a great epidemic is coming, and nothing but the general acceptance of the orthodox faith can prevent it.

THE PRESENT METHOD OF CONTROL OF SMALLPOX INFECTION.

Our modern method was only made possible by the Notification of Infectious Diseases Act of 1889, for notification made it possible effectively to circumscribe infection, both by the isolation of the infectious in hospital, and by the surveillance and vaccination of contacts. Variola major must initially have come from overseas, as we live on an island, and cases and most contacts are now adequately dealt with on arrival. Occasionally, however, a contact arrives unrecognized, and still more rarely is not diagnosed when he develops the disease, but of recent years the case or cases to which he gives rise have invariably been diagnosed, the infection circumscribed, and the outbreak rapidly brought to an end.

It is clear that vaccination should be made as attractive as possible to ensure vaccination of contacts. One method of so doing depends on the fact that though immunity is established on the eighth day after

vaccination, if the vaccinal area is excised on the fifth day immunity is still attained. It is therefore good practice to disinfect the vaccinal area on the sixth or seventh day by means of pot. permang. compresses, for these allay irritation, and should diminish the risk of septic complications. (Pot. permang. baths and compresses are invaluable both in variola and varicella.) Another method of making vaccination more attractive is to lessen the dose, as an evanescent protection is adequate for an epidemic. But unfortunately this is against the orthodox tenet, for an epidemic is employed as a means of getting as many people immunized as possible in preparation for a hypothetical future epidemic; yet they do not seem to realize the temporary nature of the immunization from even the maximum dose of vaccine, and the improbability of exposure to fresh infection during the period for which it would be efficacious. If administrative efforts, then, were concentrated on the infection present to the exclusion of provision for a hypothetical future, epidemic treatment should gain in efficiency.

Epidemic treatment has not been successful in the case of variola minor, but during the same period it has been successful in the case of the several introductions of variola major infection, and the explanation, in the case of the major infection, is that the patients follow the advice of the authorities; in the case of the minor form, on the other hand, they regard it as trivial, and so do not follow the official advice.

To summarize, I regard the B.M.A. Confession of Vaccinal Faith as an entirely abstract one, and as impossible to put into practice, as would be the advice to stay in bed to avoid street accidents. Its futility is demonstrated by formulating what it entails as a practical proposition, and recording the unvaccinated state of the population, and the exceeding rarity of variola major infection during the last thirty years. This may be attributed to the efficient method of dealing with the infection when introduced into this country; as the great epidemic predicted by the orthodox entails the breakdown of this method, however, I briefly suggest possible improvement, deploring the imperfect subdivision of smallpox into its major and minor forms by the authorities—a procedure which is easy, and attempted at least by the lay press.

In fact, I regard the orthodox faith because of its antiquity as one not to be sanctioned, but to be questioned, for the vaccination problem is an important one, and when the public and the profession are at variance, it is for the younger members of the profession with open minds to resolve the problem.

R. W. JAMESON.

REMARKS ON DR. JAMESON'S PAPER CONCERNING SMALLPOX AND VACCINATION.

By M. H. GORDON, D.M., F.R.S.



THE protection afforded against smallpox by the inoculation of cowpox virus is one of the best established facts in the whole field of medicine, and it may interest some of the readers of the Journal to know that Jenner's original monograph of 1798, and the second edition of it presented by the author to Abernethy with an inscription in Jenner's writing, are among the treasures in the Hospital Library. Jenner studied cowpox for over twenty years before he brought out his first paper, and was not content merely with a careful record of instances where persons who had naturally acquired cowpox afterwards escaped smallpox; he delayed publication until he had actually made the experiment of first inoculating the normal human subject with cowpox virus, and then proving that the subsequent inoculation of smallpox virus was without effect. In a report to the Government on vaccination nine years later (1807), the Royal College of Physicians remarked that this experiment of Jenner's on the human subject had been repeated and confirmed thousands of times: In fact, some had even inoculated smallpox several times to make sure. Jenner, of course, made mistakes, as pioneers must; but he remains for all time one of the greatest and most inspiring of our medical pioneers.

As all immunity is relative, so the immunity against smallpox conferred by vaccination is no exception. It seems likely that the duration of the immunity is greater against weak strains than against more virulent strains of smallpox. At any rate most medical men who come in contact with smallpox are revaccinated, and advise others to do the same.

Dr. Jameson, I take it, accepts all this, and his "heterodoxy" relates chiefly to the present policy pursued by the public authorities in regard to compulsory vaccination. There is no doubt that here he has a case, and his earlier efforts to get official sanction for the distinction between variola major and minor have already been partly successful. But although these two forms seem to breed true, the sole difference, so far as can be seen from serological and other tests between the viruses of variola major and minor, is that of virulence. Now virulence is an attribute about which comparatively little is known. It is conceivable

that a particularly favourable soil, or some fortuitous association with another virus or another unknown factor might enhance the virulence of a strain of variola minor. One can quite see, therefore, that responsible Public Health Authorities may well hesitate before committing themselves and the State to what would, in the eyes of some, constitute something of a gamble.

There is another side to the whole problem, namely, whether it may not be possible to produce immunity to smallpox by some measure less severe than the cutaneous inoculation of a living virus. Even though that is the comparatively benign virus of cowpox, some few persons have been known to develop grave sequelae, and no method of immunization, however effective, can be regarded as satisfactory so long as that is the case. There are certain recent experimental observations on rabbits by Tulloch and Craigie, for instance, that suggest (1) that by employing a particularly virulent strain of vaccinia an exceedingly potent protective antiserum can be prepared, and (2) that by using sensitized virus, *i.e.* virus flocculated by this antiserum, a certain degree of immunity can be produced without any lesion. Progress, however, along these and other lines will be slow until these methods are tried on the human subject, and at present there does not seem to be any enterprise in this country for doing that. In this respect Jenner and his contemporaries enjoyed an advantage that has now gone. In view of the slowness of progress in the practical immunization against other virus diseases affecting the human subject, it may be of considerable significance that the specific immunization against smallpox has reached its present high state of efficacy entirely by observations on the human subject.

With regard to recent outbreaks of variola major, the success of the authorities in limiting them is certainly remarkable, and active vaccination has probably been the most important single factor in that success. It is very fortunate that even after exposure to smallpox infection immunity can be produced and an attack prevented, provided that vaccination is done at once, or within a day or so. There can be little sympathy with people who refuse vaccination or revaccination under such circumstances. At the same time there is such a thing as progress, and if variola maxima returns, something might be attempted in the way of specific treatment. It would be interesting to know, for instance, whether serum from normal persons 11-14 days after vaccination or revaccination is of benefit; according to animal experiments with vaccinia the 14th day is the best on which to collect the serum. The Lister Institute also now have an antivaccinia (horse) serum that might be tried.

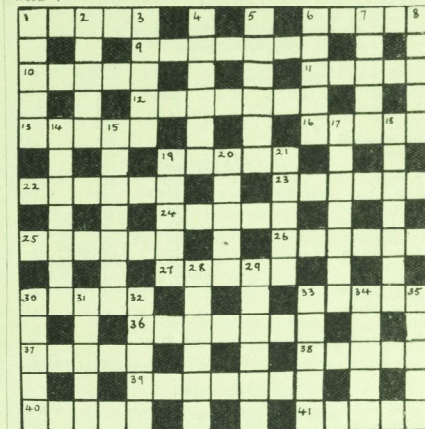
COLLEGE APPEAL FUND.

SUBSCRIPTIONS TO DATE.		£	s.	d.	*
Staff		12,672	15	10	(71)
Demonstrators		1,695	11	0	(68)
Students		765	6	5	(287)
Old Bart.'s men:					†
‡Bedfordshire		25	3	6	(7)
‡Berksire		121	1	0	(15)
‡Buckinghamshire		76	19	0	(14)
‡Cambridgeshire		183	6	0	(17)
‡Cheshire		4	14	6	(3)
‡Cornwall		31	11	0	(8)
‡Cumberland		5	0	0	(1)
‡Derbyshire		19	14	0	(4)
‡Devonshire		558	15	0	(52)
‡Dorset		52	1	0	(14)
‡Durham		17	7	0	(4)
‡Essex		253	2	6	(20)
‡Gloucestershire		225	15	0	(23)
‡Hampshire		452	8	0	(43)
‡Herefordshire		14	4	0	(5)
‡Hertfordshire		84	11	0	(16)
‡Huntingdonshire					(1)
‡Isle of Wight		181	13	0	(12)
‡Kent		569	9	0	(66)
‡Lancashire		91	4	6	(12)
‡Leicestershire		136	15	0	(7)
‡Lincolnshire		24	13	0	(5)
‡Middlesex		385	0	0	(21)
‡Norfolk		167	15	6	(*)
‡Northamptonshire		59	4	0	(5)
‡Northumberland		101	1	0	(2)
‡Nottinghamshire		19	19	0	(3)
‡Oxfordshire		185	3	0	(18)
‡Rutland					(2)
‡Shropshire		35	9	0	(8)
‡Somersetshire		1,024	16	0	(28)
‡Staffordshire		194	18	0	(6)
‡Suffolk		200	6	6	(21)
‡Surrey		466	17	6	(53)
‡Sussex		401	16	0	(57)
‡Warwickshire		178	1	6	(18)
‡Westmorland		2	10	0	(1)
‡Wiltshire		110	11	0	(12)
‡Worcestershire		160	0	6	(24)
‡Yorkshire		282	0	6	(23)
‡Wales		59	7	0	(14)
London		2,861	19	8	(190)
Channel Islands		20	0	0	(2)
Scotland		14	4	0	(4)
Abroad		48	5	0	(7)
South Africa		302	15	6	(19)
Canada		113	2	6	(8)
East Africa		82	7	0	(9)
West Africa		146	10	0	(5)
India		197	0	0	(10)
Ceylon		4	0	0	(1)
Syria		2	2	0	(1)
U.S.A.		5	0	0	(1)
Ireland		14	14	0	(3)
North Africa		1	0	0	(1)
North Borneo		5	5	0	(1)
Australia		17	2	0	(4)
Fiendly Islands		1	1	0	(1)
Egypt		5	3	0	(2)
Malay States		6	0	0	(2)
China		52	8	4	(9)
Siam		16	0	0	(1)
France		59	0	0	(1)
Trinidad		22	2	0	(2)
British West Indies		28	6	0	(3)
Straits Settlements		1	1	0	(1)
New Zealand		2	1	0	(2)
Services		551	12	6	(40)
Others		32,393	11	1	(322)
		59,329	12	4	

* Number of Bart.'s men subscribing. † Number of Bart.'s men in County. ‡ Counties with Secretaries.

CROSSWORD PUZZLE.

Solutions may be sent to the Editor. A *de luxe* copy of *Round the Fountain* will be given to the sender of the first correct solution opened after September 20th. Envelopes should be marked "Crossword".



ACROSS.

1. Tail-waggers? 6. Boasts of five less.
 9. It's all right in 100 mu. 10. An egg about a salt.
 11. Nephric.
 12. Calculate, the duty on a bird?
 13. Virgil's indignatio.
 16. Louse (ang.).
 19. Allude paindromically.
 22. Symptomatic drought.
 23. Lilies. 24. C₆H₆N.
 25. Makes sable.
 26. The hunter of these may be a wryneck.
 27. Palliates.
 30. " — not a falling man too far " (Shakespeare).
 33. Vessels.
 36. " Just a mass of nerves, Doctor! "
 37. Peach or almond.
 38. May be present, under pressure.
 39. Behelved slave.
 40. "... his native — brought him serenely through " (Spurgeon).
 41. Piles.
- DOWN.
1. Roman dog.
 2. " As though of — I had drunk " (Keats).
 3. A salt is twice docked.
 4. Characteristic of pre-Raphaelite beauty!
 5. Little Diana behind time.
 6. " Ah, don't say that you — with me! " (Oscar Wilde).
 7. 5th inst.
 8. It's most of all in the sun.
 14. Let's do away with the A.R.
 15. A tube containing grain would be distended.
 17. Result of 22 perhaps.
 18. This could be on metal.
 19. Cause to arise.
 20. " Now — the glimmering landscape " (Gray).
 21. Noises within.
 28. " If ever a people required to be — it is we sad-hearted Anglo-Saxons " (Helps).
 29. Great going out. 30. Nerve of blushing?
 34. Get out of. 32. His tongue will be slit.
 33. Famous stylist. 34. First school of Greek philosophers.
 35. Hats without a boy.

STUDENTS' UNION.

CRICKET.

AVERAGES, SEASON 1934.

1ST XI—BATTING.

Name.	Number of innings.	Times not out.	Highest score.	Total runs.	Average.
G. D. Wedd	11	1	96*	364	36.4
R. M. Kirkwood	13	1	77	404	33.7
R. Mundy	13	2	105	342	33.1
C. M. Dransfield	11	1	87	291	29.1
C. R. Morison	16	..	81	441	27.5
W. M. Capper	9	..	65	176	19.5
R. C. Dolly	14	2	85*	211	15.1
J. B. Bamford	3	1	20*	28	14.0
C. G. Nicholson	8	..	37	107	13.4
W. M. Maidlow	13	..	31	170	13.0
J. D. Anderson	8	..	34	99	12.4
D. J. A. Brown	12	1	32	112	11.1
J. D. Wilson	8	..	35	79	9.9
J. G. Berry	3	1	11*	18	9.0
G. A. Akeroyd	4	2	6*	10	5.0
G. V. H. Wade	3	..	7	13	4.3
S. Littlepage	4	..	7	16	4.0
J. C. Cochrane	8	3	7*	10	3.2

* Denotes not out.

1ST XI—BOWLING.

Name.	Runs.	Wickets.	Average.
C. R. Morison	95	10	9.5
C. M. Dransfield	110	12	9.2
C. G. Nicholson	173	14	12.3
J. C. Cochrane	282	22	12.8
J. D. Anderson	312	22	14.2
R. Mundy	429	27	15.5
G. D. Wedd	335	20	16.7
R. C. Dolly	132	7	21.7
S. Littlepage	66	3	22.0
J. R. Simpson	32	2	26.0

Runs for, 3267; wickets 150; average per wicket, 20.5. Runs against, 2974; wickets 177; average per wicket, 16.7.

SAILING CLUB.

HARVEY CUP.

This has been lost to London Hospital. The Bart's boat "Osprey" has been placed in the first three in five races out of seven, the average number of starters being five to six. On one occasion when we were not placed the main rigging was carried away in a squall, and fortunately there was no other damage. On the second occasion the "Osprey" was lying second on the run home when she filled with water and capsized. This was excusable to some extent! The weather was extremely bad, and out of seven starters only two finished the race. The helmsman and crew—Barrett and W. A. Cobb—had rather an anxious time before they were rescued. Evidently they found clinging to wreckage in a seaway somewhat exhausting.

BOURNE TROPHY.

Bart's is at present leading, having a first and two thirds out of three starts. There are, however, seven more races.

WILSON CUP.

Of seven entries from St. Bart's, two have reached the final heat, there being only three others in the heat. The Final is to be sailed on September 2nd.

DOUBLEDAY CUP.

Members are reminded that should they go for a cruise in any time from a yacht downwards they should keep a strict log which they

might enter for the Doubleday Cruising Cup. This is presented for the best cruising log for the year. The most important rule is that the cruise should be sailed under the burgee of the U.H.S.C.

BART'S REGATTA.

Sailed on April 28th this was a great success. All the boats were used. The race was a good one and not without amusement.

THE CLUB HOUSE.

This has at last arrived at Burnham and it is hoped that members will take every opportunity of using it. The standard of comfort at first will be that of a good cruising yacht. There is sleeping accommodation, and meals can be obtained on board at any time during the weekend. Charges for bunks and meals will be extremely moderate.

REVIEWS.

X-RAY AND RADIUM INJURIES. By H. A. COLWELL, M.B., Ph.D., M.R.C.P., D.P.H., and SIDNEY RUSS, C.B.E., D.Sc., F.Inst.P. (Oxford University Press: Humphrey Milford, 1934.) Pp. 205. Price 14s.

This book provides an excellent and systematic account of the injuries which may be produced from X-rays, and it will be seen from it that the types of injury that can be produced are as many as the tissues that make up the human body. Fortunately, however, the great majority of them occur only under experimental conditions, and such of them as are observed clinically, and are of any severity, are much commoner in radiologists, radiographers, X-ray tube and instrument makers, physicists and laboratory assistants, than they are in patients who come for treatment. These occupational injuries take the form of chronic X-ray dermatitis, often leading to carcinoma, and anemias of varying degrees, occasionally leading to a fatal termination by aplastic anaemia. Sterility, both in male and female, may also occur. As affecting patients, skin erythemas are an everyday occurrence, and are deliberately produced in the practice of X-ray therapy. They are not regarded as a serious injury. True X-ray burns, however, are rare, and serious burns are very rare indeed. Other varieties of injury met with after therapeutic irradiation affect the lungs, and occasionally the larynx, causing perichondritis. Admirable and detailed accounts of all these types of radiation injury are given in the volume under review. The power of X-rays to produce sterility has long been known. It is often observed as an unavoidable effect when serious pelvic disease has to be treated by heavy doses of radiations. Therapeutically this effect is often employed in the production of an artificial menopause. During the first half of the child-bearing age recovery can occur from X-ray sterility, and temporary sterilization is often recommended and carried out, principally by German gynaecologists, for various conditions. This procedure has led to a good deal of controversy as to the possibility of injurious effects being produced upon the children born after recovery from temporary sterilization. This book contains an admirable survey of the present state of opinion on this subject, and the authors conclude that the bulk of opinion is against temporary sterilization, and they rightly state that "as a contraceptive it is without question to be condemned". The book is well written, although illustrations are somewhat scanty, and it provides a mine of information on its subject.

W. M. L.

MEDICAL BACTERIOLOGY—DESCRIPTIVE AND APPLIED, INCLUDING ELEMENTARY HELMINTHOLOGY. By L. E. H. WHITBY, C.V.O., M.D., F.R.C.P., D.P.H. (London: J. & A. Churchill, 1934.) 5 in. by 8½ in. Pp. x + 338 + 16. 74 figures. Price 10s. 6d.

The problem that besets the student as to which books to buy is an ever-increasing one, what with the seductions of the publisher's "blurbs" on the one hand, and the excessive inquisitiveness of examiners on the other; and in the matter of books on pathology it is as difficult as any.

Obviously a standard text-book of general pathology is essential, and possibly a small book on post-mortem appearances or morbid anatomy, and some would even have a book of so-called "surgical pathology"; but in addition something on bacteriology is necessary, and until recently a suitable book was difficult to find. There were

many excellent text-books which were unnecessarily large, there were a few small cram-books which were undoubtedly bad, and furthermore the moderate-sized books usually omitted all mention of parasitology. In 1928 appeared Dr. Whitby's *Medical Bacteriology*, and the want was to a large extent fulfilled; the second edition has just been issued and is even better.

The book is divided into three parts. The first deals with the general properties of bacteria, methods of cultivation, and staining, and in this section are excellent chapters on bacteriological variations and their significance, and a most useful one on common contaminating organisms. Though it is hardly surprising that our native *B. fabragearius* is omitted.

In the second part the pathogenic organisms are dealt with in detail, followed by chapters on viruses and the more important worms and protozoa. The title may be a little misleading owing to the adjective "medical" being so often taken to mean only a part of the doctor's art, but in Dr. Whitby's book it will be found that tetanus is as carefully described as typhoid, and *Brucella melitensis* as *Bacillus mallei*. Although the illustrations of the various micro-organisms are excellent, yet certain of the parasites (in particular malaria) are by no means too clearly displayed, and it is a pity that no ringworm fungi are illustrated.

The last parts deal with applied bacteriology, the use of bacterial preparations, the methods of collecting specimens, and the bacteriological procedures appropriate to individual diseases, both diagnostic and therapeutic.

Obviously in a work of this size, where a vast field has had to be compressed into a very small compass, the author is forced into dogmatism, and in one or two places this has resulted in a lack of clarity; nevertheless the book can be wholeheartedly recommended to students, practitioners and clinical pathologists, for it will solve their problems, whether it be the habits of the *Bitharsia*, the methods of immunization in diptheria, or the carrying out of a Rideal-Walker test.

MANIPULATIVE TREATMENT FOR THE MEDICAL PRACTITIONER. By T. MARLIN, M.D., M.B., Ch.B., D.P.H., R.C.P.S. (Eng.), D.M.R.E. (London: Edward Arnold & Co.) Pp. vii + 133. Figs. 86. Price 10s. 6d.

There are certain conditions which "cry out" for manipulation, and others in which such treatment is dangerous. Any volume which claims to deal with "manipulative treatment for the medical practitioner" must clearly indicate the affections in these two categories. In this respect the book fails, and we cannot recommend it to those relatively unacquainted with manipulative work. To those already accustomed to it this will be of interest as describing, with good illustrations, alternative methods, many those of the osteopath. Little mention is made of anaesthesia, and we read: "Having thus fixed the thigh with the strap, the operator is in a position to subject the knee to very considerable movement. The patient feels so helpless in this position that he offers very little resistance." One other phrase must be quoted as illustrating in exaggerated fashion an unscientific strain which runs through the book: "I am a firm believer in the healing power of a healthy hand sympathetically applied to the patient's skin . . ."

The statement of a well-known "bone-setter" that the mysteries of manipulative treatment cannot be imparted by books is but a half truth, and the fact that manipulations may be seen in quantity and practised by students in this Hospital on any Friday afternoon need not dissuade them from seeking the printed word on this important subject—but this is not just the book we would advise.

DISEASES OF WOMEN. By THE TEACHERS. Edited by COMYNS BERNSEY, J. S. FAIRBAIRN and CLIFFORD WHITE. FIFTH EDITION. (London: Edward Arnold & Co., 1934.) Pp. xii + 568. With 8 plates and 185 figs. Price 18s.

This is a text-book ideally suited both to the student and general practitioner, and represents a product of collective authorship at its best; for it is uniformly well written, and at all times clear and concise, with excellent illustrations throughout.

In this edition a full account has been given of the principles of new work on the ovary and ductless glands, particularly in their relation to menstruation and its disorders. The authors, however, have not overstated the case from the clinician's point of view, and no extravagant claims are made for therapeutic measures as yet, based upon endocrine stimulation. It is perhaps surprising, on the

other hand, that greater importance is not attached to the operation of sympathectomy for dysmenorrhoea than the very brief mention of it in this book.

The chapter on Endocervicitis is good, and the subject of radium and X-ray therapy is well treated in a short space. It also seems wise, as the authors have done, to describe operative details in a section by itself. The question of Prolapse is well discussed here, but, in the chapter on the subject, it would surely be an advantage to include illustrations of the various types of pessary in common use.

The paper is good, and the book of a convenient size, and much to be recommended both to students and general practitioners.

EXAMINATIONS, ETC.

University of Cambridge.

The following degrees have been conferred:

M.D.—Langford, A. W., Maclay, The Hon. W. S., Oakley, W. G., Richards, F. A., Taylor, H., Windle, R. W.

M.B., B.Chir.—White, H. D.

M.B.—Carr, C. M., Westwood, M.

B.Chir.—Hadfield, S. J., Levick, R. E. K., Martin, C. J., Neill, E. J.

University of London.

M.D. Examination, July, 1934.

Branch I (Medicine).—Anderson, H. G., Keele, K. D., *Renbom, E.

*Awarded a mark of distinction.

M.S. Examination, July, 1934.

Branch I (Surgery).—Trevor, D. (University Medal).

First Examination for Medical Degrees, July, 1934.

Ambrose, A. R., Anderson, A. C., Arango, R. E., Atwill, J. A., Barwood, A. J., Blanchard, T. P., Bose, C. F., Cates, R. N., Clarke, T. H. W., Cooper, R. S., Corsi, E. L., Crabb, E. R. T., Davies, I. R., Donkin, W., Elmhorst-Baxter, E. M., Finnegan, J. D., *Fisk, G. R., Gillingham, F. J. V., Gimson, P. A., Goodman, P., Gunz, F. W., Hart, I. R., Hayes, S. T., Howitt, J. S., Jackson, C. A., Jones, H. B., Kingston, R. F., Langdon, T. C., Lillierup, J. S., Linton, J. S. A., Lockyer, N. S., McShine, L. A. H., Messert, J. J., Morley, T. R., Nicolas, J. C. H., Renold, D. G., Rogers, N. C., Savidge, R. S., Shuttleworth, V. S., Syred, D. R., Tatlow, W. F. T., Thams, M., Thompson, F. A., Warrick, C. K., Williams, E. H., Wince, W. H. D.

*Awarded a mark of distinction in Inorganic Chemistry.

Second Examination for Medical Degrees, July, 1934.

Part I.—Arango, C. M., Arden, L. D., Brown, D. J. A., Burnett, J. A., Butler, K. A., Craig, C. M., Curtin, A. P., Desmarais, M., Evans, E. O., Garrod, O., Hackett, J. T. A., Hughes, J. F., Jackson, C. A., Jones, H. B., Maycock, K., Morley, T. K., Nicholson, C. G., Page, W. J. O., Porter, A. S., Ramsay, R., Simpson, J. R., Tados, V. R., Turner, E. W., Vincent, S. E.

Part II.—Bacon, A. H., Braines, F. M., Brown, K., Carnarvon, Carey, C. J., Darke, G. H., Foster, W. B., Grant, A. H., Harrison, R. J., Jack, A. H., Ramsay, F., Rendall, D. C. S., Rutherford, S. T., Sugden, W. G., Tados, V. R., Thomson, A. H., Tonghai, B., Waring, J. W. B.

Royal College of Physicians.

The following has been admitted a Member: Keele, K. D.

Royal Colleges of Physicians and Surgeons.

The following Diploma has been conferred:

D.T.M. & H.—Helme, A. C. de B.

British College of Obstetricians and Gynaecologists.

The following has been admitted a Member: Gwillim, C. M.

Conjoint Examination Board.

Pre-Medical Examination, July, 1934.

Chemistry.—Daniel, H. G., Jackson, C. A., Williams, G. T. S.

Physics.—Daniel, H. G.

Biology.—Bell, C. J., Conte-Mendoza, H., Mayberry, W. M., Moseby, W. G., Rutland, F. A.

First Examination, July, 1934.

Anatomy.—Cane, C. S., Flavell, G., Halper, N. H., Jackson, K. V., Joyce, J. B., Kershaw, R., Richards, G. A., Schenker, A. W., Thompson, J. R. O., Witt, R. C.

Physiology.—Cane, C. S., Coates, H., Flavell, G., Joyce, J. B., Mundy, N. B., Richards, G. A., Schenker, A. W., Stevenson, R. Y., Thompson, J. R. O., Williams, W. R.

Pharmacology.—Ali, M. M., Gray, G., Maidlow, W. M., Saltman, P. B. L., Stevenson, R. Y., Suzden, K. H., White, D. M.

Final Examination, July, 1934.

The following students have completed the Examinations for the Diplomas of M.R.C.S., L.R.C.P., and have had the Diplomas conferred on them:

Byer, I., Clarke, R. F., Collingwood, S. G., Culshaw, F. H., Davies, D. L. L., Dias, N. J., Fulton, I. N., Harris, E. E., Howell, T. H., Hughes, J., Jenkins, J. R. R., Jones, D. M., Kirkwood, R. M., Laverick, J. V., Livingstone, F. D. M., MacCarthy, D., McCoy, D. P., Masterman, E. B. Z., Purnell, R. H., Ross, W. T., Sivolella, N. W., Stallard, A. F., Walsh, R. C., Weiner, B.

CHANGES OF ADDRESS.

DAHNE, S. F. LOGAN, "Meadowcroft", Conishore Avenue, Caversham.

DE LABILLIERE, Surg.-Lt. C. D. D., R.N., H.M.S. "Leith", New Zealand Waters, c/o G.P.O., London.

ELGOD, C., 18, Lungarno Acciaioi, Florence.

LYDD WILLIAMSON, J. C. F., 34, The Drive, Hove, Sussex. (Tel. Hove 1623.)

MAITLAND, C. T., Lethington, Vicarage Way, Gerrards Cross, Bucks.

MAXWELL, J. PRESTON, 14, Barrow Road, Cambridge.

SHAW, WILFRED, 109, Harley Street, W. 1. (Tel. Welbeck 7395.)

WALKER, F. H. AITKEN, 16, Westcote Road, Reading, Berks. (Tel. Reading 2390.)

APPOINTMENTS.

LYDD WILLIAMSON, J. C. F., M.B., B.Chir.(Cantab.), F.R.C.S., appointed Honorary Surgeon to Horley and District Cottage Hospital, and Honorary Surgical Registrar to the Royal Sussex County Hospital, Brighton.

WINDLE, R. W., M.D.(Cantab.), appointed Honorary Medical Registrar to the Royal Sussex County Hospital, Brighton.

BIRTHS.

ALDRIDGE.—On July 17th, 1934, at 20, Devonshire Place, to Betty, wife of Dr. J. S. Aldridge—a son.

BENNETT.—On July 25th, 1934, at Wilmslow, to Dorothy Margaret, wife of Dr. Randle Bennett—a son.

BRIGG.—On August 22nd, 1934, at Chipping Norton, Oxon, to Kitty (*née* Jackson), wife of D. A. Brigg, M.B.—a daughter.

CHAMBERS.—On August 9th, 1934, at 36, Bolton Gardens, S.W., to Senga, wife of Guy Chambers, F.R.C.S.—a son.

DONALDSON PERROTT.—On July 19th, 1934, in London, to Louie, wife of Dr. G. F. Donaldson Perrott—a daughter.

MARSHALL.—On July 3rd, 1934, at 20, Devonshire Place, W. 1, to Betty (*née* Rowlands), wife of Dr. R. M. Marshall, of Brockenhurst—a daughter.

SCOTT.—On July 24th, 1934, to Daphne, wife of Dr. Ronald Bodley Scott, 11, Poole Road, Bournemouth—a daughter.

VISICK.—On July 5th, 1934, at 25, High Petergate, York, to Christine and Arthur Visick—a son.

WHITE.—On August 10th, 1934, at Green Trees, Bassett, Southampton, to Alice (*née* Tait), wife of Dr. H. Oakley White—a son.

MARRIAGES.

MCBRIDE—FREEMAN.—On July 28th, 1934, at Christ Church, Lancaster Gate, Dr. John Richard Best McBride to Kathleen Beryl Howard Freeman (Kathleen Wike).

TRACEY—ROSE.—On July 28th, 1934, at St. Mary's, Attleborough, Norfolk, by Rev. H. M. Mills, John Brodrick Tracey, B.A., B.Chir., sixth son of the late Dr. H. Eugene Tracey and Mrs. Tracey, of Willand, Devon, to Mabel Joy, only daughter of Dr. and Mrs. E. F. Rose, of Attleborough.

SILVER WEDDINGS.

HUGO—NEWTON.—On July 7th, 1909, at St. John's Church, Dalhousie, by Rev. G. A. Campbell-Bell, Major E. V. Hugo, I.M.S., to Helen Frances, third daughter of Mr. E. J. Newton, Peterborough. Present address: 75, Queen's Road, Richmond, Surrey.

MOORSHEAD—WINCHESTER.—On July 1st, 1909, at Westcliffe Baptist Church, Bournemouth, Robert Fletcher Moorshead, M.B., F.R.C.S., to Gertrude, eldest daughter of the late Dr. Henry Winchester, of Fort Augustus, Inverness-shire.

DEATHS.

COLLINS.—On June 17th, 1934, Octavius Augustus Glasier Collins, M.R.C.S., F.R.C.P., of Bath.

CROSS.—On July 14th, 1934, at his residence, Clay Point, Flushing, Falmouth, Cornwall, William Foster Cross, M.R.C.S.(Eng.), L.R.C.P.(Lond.), aged 61.

DAHNE.—On July 28th, 1934, at Pendine, Carmarthenshire, Constant Gustav Logan Dahne, L.S.A.

FISHER.—On August 16th, 1934, at Maidstone, Dr. Henry Holdrich Fisher, aged 72.

HEATH.—On July 13th, 1934, at 53, York Terrace, N.W. 1, Charles Joseph Heath, F.R.C.S., President of the Wildfowlers Association, and late of 34, Devonshire Place, W. 1.

HUTT.—On August 20th, 1934, at 35, Ennerdale Road, Kew Gardens, Cecil William Hutt, M.A., M.D., B.Ch., M.R.C.P., D.P.H.(Oxon.), aged 54.

JAMES.—On July 6th, 1934, at 38, Friends Road, Croydon (formerly of 54, Park Lane), as the result of gas poisoning incurred during the Great War, while attached to the 2nd Batt., Seaforth Highlanders, Philip William James, M.C., M.D., eldest son of the late Canon Mark James, of Hamilton, Bermuda.

JENNINGS.—On July 5th, 1934, at 13, John Street, Mayfair, John Frederick Jennings, M.B.(Lond.), F.R.C.S.

MAWER.—On July 1st, 1934, Percy Uvedale Mawer, M.R.C.S., L.R.C.P., of 11, Wimpole Street.

RANKING.—On July 14th, 1934, at Caversham, Reading, George Spiers Alexander Ranking, C.M.G., Lt.-Col. (retired), I.M.S.

ROSS.—On July 4th, 1934, at The Crescent, 346, Kingsland Road, E. 8, David Ross, M.D., aged 62.

SCORER.—On July 1st, 1934, at St. Cuthbert's, Christchurch Road, Bournemouth, after a long illness patiently borne, Frank Scorer, M.B.E., M.R.C.S., L.R.C.P.

WICKHAM.—On August 10th, 1934, at Cobbles, Sutton Scotney, George William Wickham, L.R.C.P., L.R.C.S., L.R.F.P.S., L.S.A.

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: National 4444.

