

## Calendar.

April, 1901.

Tues.,	April 2.	—Dr. Gee and Mr. Langton's duty.
Fri.,	" 5.	—GOOD FRIDAY. Sir Dyce Duckworth and Mr. Marsh's duty.
Sun.,	" 7.	—EASTER DAY.
Mon.,	" 8.	—BANK HOLIDAY.
Tues.,	" 9.	—Dr. Hensley and Mr. Butlin's duty. Conjoint Board. Final Examinations begin.
Fri.,	" 12.	—Sir T. Lauder Brunton and Mr. Walsham's duty.
Tues.,	" 10.	—Sir W. S. Church and Mr. Willett's duty.
Fri.,	" 19.	—Dr. Gee and Mr. Langton's duty.
Tues.,	" 23.	—Sir Dyce Duckworth and Mr. Marsh's duty. Cambridge Third M.B. Examination begins.
Fri.,	" 26.	—Dr. Hensley and Mr. Butlin's duty.
Tues.,	" 30.	—Sir T. Lauder Brunton and Mr. Walsham's duty.

## Junior Staff for April—October, 1901.

## HOUSE PHYSICIANS.

Senior.	Junior.
Sir William Church.	
T. Gillespie.	A. H. Hayes.
Dr. Gee.	
W. P. S. Branson.	A. T. Pridham.
Sir Dyce Duckworth.	
W. S. Darby.	F. C. Shrubsall.
Dr. Hensley.	
J. A. Nixon.	S. Hey.
Sir Lauder Brunton.	
C. W. von Bergen.	A. H. Bostock.

## HOUSE SURGEONS.

Senior.	Junior.
Mr. Willett.	
H. B. Gibbins.	C. E. West.
Mr. Langton.	
C. A. S. Ridout.	F. E. Brunner.
Mr. Marsh.	
J. G. Cooke.	W. S. Danks.
Mr. Butlin.	
F. A. Rose.	H. G. Pinker.
Mr. Walsham.	
C. S. Hawes.	R. T. Worthington.

## RESIDENT MIDWIFERY ASSISTANT.

J. A. Willett.

## OPHTHALMIC HOUSE SURGEON.

L. E. Whitaker.

## ASSISTANT CHLOROPORMISTS.

W. F. Cross and H. S. Ward.

## EXTERN MIDWIFERY ASSISTANT—April.

S. R. Scott.

## EXTERN MIDWIFERY ASSISTANT—July.

H. Vaughan Pryce.

## Appointments.

ADAMS, P. E., M.D.(Lond.), appointed a Surgeon to the Hospital Ship "Simla."

ALLEN, L. L., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon at the County Hospital, Lincoln.

COPE, R., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon at the York County Hospital.

HAY, K. R., M.R.C.S., L.R.C.P., appointed Casualty Officer to the Children's Hospital, Shadwell.

NANCE, H. C., F.R.C.S.(Eng.), appointed Surgeon to the Jenny Lind Hospital for Sick Children, Norwich.

SCOTT, R. B., B.C.(Cantab.), appointed Assistant House Surgeon to the Gloucester General Infirmary.

SKELDING, HENRY, M.B., B.C.(Camb.), M.R.C.S., appointed Honorary Surgeon to the County Hospital, Bedford.

## New Addresses.

BREWER, A. H., Cotswold, Fairholt Road, Stamford Hill, N.  
 HARRISON, L. H., 320, Humberstone Road, Leicester.  
 HORDER, T. J., 141, Harley Street, W.  
 LEGG, T. P., 141, Harley Street, W.  
 MAXWELL, J. L., F. P. Mission, Tainanfoo, Formosa, Hong-Kong.  
 ROBINSON, C. A., Gladwin's, Limpfield.  
 THOMSON, C. C. B., Chepstow, Mon.  
 VINCENT, K., 1, Harley Street, W.  
 WINTER, L. A., 27, Cedars Road, Beckenham.

## Marriages.

COCHRANE—RICHARDSON.—On February 28th at Gurdaspur, Punjab, by the Venerable the Archdeacon of Lahore, Archer Cochrane, M.B., F.R.C.S., Captain I.M.S., Punjab Asylum, Lahore, India, to Winifred, daughter of Colonel Richardson, I.M.S. (retired), of College Gardens, Dulwich.

THORNE—SINGLETON.—On the 21st inst., at Christ Church, Lancaster Gate, W., by the Rev. G. R. P. Preston, M.A.(Oxon.), Leslie Thorne Thorne, M.D., of 45, Inverness Terrace, W., second son of the late Sir Richard Thorne Thorne, K.C.B., F.R.S., of Marcella Mildred, second daughter of Edward Singleton, Esq., of East Brook, Teignmouth, and granddaughter of the late Hugh Singleton, of Hazelwood, co. Clare.

## St. Bartholomew's Hospital



## JOURNAL.

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APRIL, 1901.

[PRICE SIXPENCE.]

## NOTICE.

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

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

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

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## St. Bartholomew's Hospital Journal,

APRIL, 1901.

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

## To the Reader.

THE Editorial Chair is vacant, and the JOURNAL makes its appearance this month without a guiding hand at the helm, and it perchance we should offend a contemporary or a contributor, there is this satisfaction, that there is no one responsible for this issue who can be reviled or slain. For close on two years the late Editor has been in charge of this Journal, and in that time has deserved well of all its readers. For, like Pharaoh's cattle, there have been fat months and lean months; now a glut of copy, and some contributor will open his JOURNAL to find with wrath that his "magnum opus" has been

crowded out; and a time when the editorial brain is racked to fill the gaping columns. Yet through such crises has the JOURNAL come unscathed, and one man has lived who at times could truly say, "Alone I did it."

And now what is to be the lot of this orphan paper—for is not the editor its father and mother? This month it appears, but whence it comes or whither it goes who shall say?

That it can maintain its former standard is almost too much to hope. Yet if the learned among us would but write, in season and out of season, early and late; of things medical, of things surgical; of things they have seen and heard, and of that which no man has seen or heard; then may we look for a Journal which, if not as worthy of perusal as in recent years, will still contain as many pages, and appear as regularly.

For there are those who read their JOURNAL and say, "Go to, what are these things that are written of? where shall I look for news of the Ping-Pong Club?": while he that speaks is its secretary, and knows full well that if he writes not, none will.

Another communes within himself (yet not openly, for he is fearful of the mob): "How comes it that I find no voice raised against Vivisection?": when he alone could raise that voice.

Gentle readers, is it thus that you help us? Does this make copy? Better far were it that a wet towel were tied round your heads and ye were thrown into the Editorial Chair: for thus you would write of those things you love to read of.

How shall an Editor know the minds of his readers? If he writes in humorous vein he is called flippant, and if his style is more weighty he is dull; but if the readers of this Journal write, each in his own style, the witty reading it that they may laugh at their own humour, and the solemn that they may admire the depth of their learning, then we shall have no more resignations of Editors, for their lives will be full of joy and void of care, and the JOURNAL will continue, as before, a storehouse of Wit and Wisdom.

### Practical Midwifery in Primitive Culture.

By F. C. SHRUBSALL, M.A., M.B. Cantab.

**N**EITHER as a science nor as an art did midwifery, among primitive people, ever attain to the heights reached by the kindred studies, medicine and surgery. The practice of this art, whether from feelings of modesty on the part of woman or laziness on the part of man, has been left almost exclusively in the hands of the female sex, with the effect that, while in uncomplicated cases excellent results were obtained, complications were almost inevitably fatal. Among savages the sole qualification demanded of a popular midwife is that she shall have given birth to a sufficient number of children, and have sufficient idea of her own importance. In three countries alone, Egypt, India, and Japan, did the medical profession, such as it was, pay any attention to midwifery, in each distinct advances being made. In Egypt and Japan the use of the forceps and the vectis was discovered, while in India female midwives were taught the first elements of asepsis. In the Ayurveda of Susruta, dated by some authorities from the tenth century before our era, women in labour are advised to be attended by "four women of a certain age, used to attending confinements, and who have carefully pared and cleansed their nails."

The early signs of pregnancy seem to be better known to the present-day savage than they were in civilised countries in mediæval times, for while we find the negroes of the West Coast of Africa forecasting accurately from the cessation of the menses, on the other hand the faculty of Slavonian villages regarded the appearance of freckles on the face as a sure sign of pregnancy, and a distinguished Arabian physician has left the following on record as the most conclusive test: "Let the woman on retiring to bed take a drink of milk and honey, if it lie heavy on her stomach she is undoubtedly pregnant." This may be a reference to morning sickness, but there is nothing in the context to support such an interpretation; likewise the freckles mentioned above might be a reference to the increase of pigmentation noticed especially in brunettes in early pregnancy, but such increase in other situations was not alluded to by the Slavonian authorities.

Many strange precautions are taken among savages to avoid witchcraft and the influence of evil spirits on pregnant women, few, if any, being of practical importance. Among most tribes in a primitive state of culture sterility is a disgrace, and abortion rare; but in the so-called higher grades of civilisation, and in those peoples living on the outskirts of settlements, the latter becomes more common, medicinal and mechanical means being employed to bring about this result, the last and most effective resource being found, in all places and times, to be rupture of the mem-

branes by some instrumental means. In a few tribes abortifacients are administered, not with a view of destruction of the fetus, but rather of ensuring a strong progeny, the idea being that if the child *in utero* can resist their action it will necessarily be strong and healthy. Engelmann informs us that in Old Calabar medicines are first administered by mouth, and if their exhibition be followed by a blood-stained discharge, the stalk of a Euphorbia coated with pepper, introduced through the vagina is pushed a little way into the cervical canal, abortion usually following.

Among savage populations, as among our own lower classes, the pregnant woman commonly discharges her ordinary daily duties up to the very commencement of labour, no special attention being paid to her condition. With a few, however, the case is different; in Mexico she rests and takes frequent warm baths, while in Japan a binder is firmly fastened around the waist at the fifth month and not relaxed until labour is over. Abdominal massage to strengthen the muscles and rectify the position of the child, if necessary, is practised every few days in Japan, and three or four times a month in Burma from the fifth month onwards. Most savages are well acquainted with the normal duration of pregnancy, and although they regard labour as due to the voluntary efforts of the child to change its quarters, as of a chick to leave the eggshell, the time therefore being determined solely by its comfort, any great abnormalities are viewed with suspicion. The Chinese, however, believe if an infant is satisfied with its place of residence, pregnancy may last two or three years, and Engelmann has seen a Mahomedan law book which gravely admits the possibility of such a condition lasting for five years.

The etiquette of the lying-in room varies in a manner that cannot be exactly predicted from a knowledge of the race. Labour may be conducted publicly, as in the Sandwich Islands, the Andamans, and some parts of Southern India. Such was the case in eighteenth century Europe, when the long-looked-for event was made the occasion of a reception and conversation, with music and light refreshments in the bedchamber itself. On the other hand the woman may retire to the privacy of a hut constructed in the depths of the bush, as among most of the American Indians, African Negroes, and Malaysians. Some tribes show considerable skill in the abdominal diagnosis of the presentation, and a few, as mentioned above, take steps to rectify this by a kind of external version, the only natural presentation with them, as with us, being by the vertex. No people in a primitive stage of culture seem to have considered the possibility or advisability of vaginal examinations or manipulations, for which their women have much to be thankful.

Hippocrates described and advocated a method of rectifying malpresentation—presumably before or in the first stage only of labour—by succussion. The woman was held up by her four limbs in a horizontal position, and from time to time vigorously shaken, as if a sheet, not less than ten

shakes being given at any one application. A similar method is adopted in Arabia and some other parts of the East.

For the pure bred savage labour is usually short, easy, and little feared, natural selection acting through many generations having made pelvis and head mutually adaptable, women with small or ill-formed pelvises not living to propagate these evil tendencies. When, however, racial miscegenation occurs, so that the head and pelvis lose their natural correlation, labour often becomes exceedingly protracted, difficult, and in the absence of skilled assistance fatal; a state of affairs which became very evident after the occupation of the Andaman Islands as an Indian penal settlement.

It is common for the women to walk about during the first stage of labour, and some tribes, *e.g.* the Comanches, provide posts at short intervals round the lying-in enclosure to which she can cling during an actual pain. The postures adopted by savages for the second stage of labour are very interesting, the recumbent position, now almost universal in Europe, being scarcely ever met with.

The following account of this division of our subject is based upon an essay published in 1833 by Dr. Engelmann, of St. Louis, and some notes by Dr. Felkin on labour in Central Africa, contributed to the *Edinburgh Medical Journal* of April, 1884. The former author classifies postures under three heads, the upright, the inclined, and the horizontal.

The upright posture is again sub-divided into the *standing*, the *partially suspended*, and the *entirely suspended positions*.

The *standing posture* is adopted at the present day in some parts of the United States, and in the mountains of Upper Silesia. It is also met with in the Philippines, the Antilles, parts of East Central Africa, among the Sioux Indians, and the more uneducated Boers of the Transvaal.

The *partially suspended position* is assumed by hanging on to the neck either of a husband or friend, as among many of the American Indian tribes, and as was the case during the last century in the North of Scotland, or of the doctor, as prevails in Japan; or by swinging from a rope or branch of a tree, as in Mexico and the Upper Nile Valley. In the Bongo district a branch of a tree is laid horizontally between two others, so that the woman can just grasp it. In the intervals between a pain she walks up and down slowly; as soon as a pain comes on she seizes the branch with her hands, places her feet apart and then bears down. A friend squats before her to prevent the child falling to the ground. Some tribes even go so far as to tie their women in labour to a tree or pole, with their hands above the head, and leave them in that position until the child is born.

The *completely suspended position* is adopted in some parts of Brazil, the Southern States of the American Union, in some outlying German villages, and in Finland.

The inclined postures are the *sitting*, *squatting*, *kneeling*, and *semi-recumbent*.

The *sitting position* is found in all quarters of the uncivilised globe, Australia, Malabar, Central America, and West Africa furnishing abundant instances. From hieroglyphs on old Egyptian monuments it seems probable that it was a common posture at that time, while the obstetrical stool was extensively used in Europe throughout the Middle Ages.

In the Schuli district of Central Africa a log of wood is placed close to the trunk of a tree to form a seat, it is covered by a little grass and a skin. Its height is some three feet from the ground. Two feet in front of this log, and two feet from one another, two stakes are driven into the ground, each having a notch a little above the ground. The parturient woman sits upon the log, places her feet in the notches on the stakes, the upper part of which she firmly grasps with her hands, and remains in this position until she has been delivered.

In the Madi district a layer of dry sand is arranged near the woman's hut and two stakes are driven into the ground, some two feet apart, the sand sloping down towards them. The woman sits down on a skin placed upon the sand, places her feet against the stakes, and clasps her legs with her hands. Her friends take it in turn to support her back. The sand moulds itself to the woman's body, and being well pressed down in front serves as a support for the perineum.

The *squatting position*, which is the most natural of all for the expulsion of foreign bodies from the pelvis, is widely spread among latter-day savages, and has been in vogue from very early times.

Bas-reliefs on the walls of the temple at Luxor show certain Egyptian queens being delivered in this position, supported by the Hathors and numerous attendants. Statistics collected by officers of the United States Army Medical Service attached to stations in the Indian reservations, prove that protracted labour and complications of all kinds, both immediate and remote, are less frequent among women delivered in this position than among those who adopt the recumbent posture.

The *squatting position* is adopted by women in Southern Arabia, Persia, Australia, Polynesia, and some parts of Central Africa.

The *kneeling posture* is also one with a wide geographical and historic distribution. It was probably the one adopted by the Hebrews, by the Pelasgians, who occupied the islands of the Mediterranean at a time anterior to the siege of Troy, and by the mound-builders of the Stone Age in America. It was adopted in Rome, among the Arabs, and in mediæval Italy and Germany. At the present time, according to Ploss, this posture is assumed in Nicaragua, Eastern Asia, Greece, Finland, and some parts of Ireland, as well as among many tribes from all quarters of the American continent. The body may be inclined forwards,

as is customary with negroes; upright, the woman holding on to a stake, as in America; or inclined far backwards, a pad being placed under the buttocks, the abdomen protruding, and the head hanging downwards towards the floor, the customary method of delivering fat women in mediæval Italy. Some tribes adopt the knee-elbow, and even the knee-face position, especially in difficult labour.

The *semi-recumbent* position was probably the one most frequently adopted by the ancients, and is almost universally met with at some stage or other of labour among the savage races of the present time. A marble group from Cyprus represents this as the obstetric position in vogue in that country over 2000 years ago; while a scene on the friezes from the Parthenon, and a ceiling decoration in a palace of the Emperor Titus in Rome, testify to its adoption in classic times. Reliefs on the side of a Peruvian funeral urn show that formerly women in the land of the "Children of the Sun" were delivered sitting semi-recumbent in their husband's lap, a position still occasionally adopted in all quarters of the globe, and by all races, white and coloured alike. In the lower grades of civilisation, we find, however, that men become averse to doing so much work, in which case the supporter is a female friend; but among the Kalmucks a vigorous young man is selected, and well paid for undertaking this office.

The *horizontal position* is almost peculiar to modern Europe, but is occasionally met with in America and China.

In simple cases it is common for the placenta to be expelled with the woman in the same position as that adopted during the labour pains. If the woman has been delivered in another's lap, with the second's arms embracing her abdomen, it is customary for this pressure to be kept up until the placenta is expelled, and among most tribes massage and external manipulation is commonly adopted during this period. Some Indians apply a bandage or belt buckled as tight as possible to the abdomen, while among others the woman endeavours to expel the secundines by pressing her abdomen against the padded end of a stick. Primitive tribes greatly dread retention of the after-birth, a calamity they are unable to deal with, intra-uterine manipulation being unknown, save among the Chinese who introduce a blunt hook into the uterus, and pull on this, frequently producing inversion or prolapse. Most savages are content to wait a short time between delivery of the child and that of the placenta, a few, such as the Cheyenne Indians, are in a great hurry, endeavouring to remove the placenta at once by traction on the cord, a course often resulting in severe hæmorrhage, and if, as is not uncommon, the cord breaks, no further effort is made to remove the placenta itself. In cases of retarded expulsion, most tribes try traction on the cord, and some endeavouring to supplement this by inducing violent expulsive efforts on the part of the patient by the administration of emetics.

Engelmann narrates the following steps as taken by a Mexican midwife in case of retained placenta; the patient was first given a quart of raw beans, in the hope that these would swell up, and so expel the after-birth; this failing, she was vigorously choked, and finally she was placed in the lap of her husband, while he squeezed the abdomen powerfully with his encircling arms. All these methods failed, and on medical examination it appeared that the placenta was in the vagina; but the violence which had been employed proved too much for the unfortunate patient.

Primitive midwives, like modern text-books, differ as to the proper time for cutting the umbilical cord, most holding that this should be delayed until after the expulsion of the placenta; a few, as the Creek Indians of the United States, prefer severing it at once, after which, we are informed, the parturient holds the placental end for fear it should slip back into the womb. All savage tribes acquainted with the use of the ligature tie the cord either at one or both ends after section; but considerable differences arise as to the distance from the child at which this operation should be conducted. The Japanese tie close to the infant, the Comanches about a foot away. Among some tribes the cord may be cut with an ordinary knife; among others special means are employed; thus in Brazil a shell is used, and in Loango the sharp edge of the stalk of a palm leaf. In North America it is not uncommon for the cord to be gnawed through by the attendant's teeth.

So far we have dealt with normal confinements; we may now briefly consider the treatment of difficult labour. Among all primitive people and at all times massage and external manipulations have been adopted to rectify malpositions, and stimulate flagging uterine and abdominal musculature. The further methods employed in cases of delay are shaking expression, and attempts to dilate and soften the perineum. Hippocrates recommended that the patient be strapped to a couch, which was then set up on end on a bundle of faggots, and lifted up by strong men, and regularly bumped down with each pain. In some parts of Arabia, Finland, and Southern India the woman is shaken like a laden sack to endeavour to remove the fetus.

The methods of expression have been thus classified by Engelmann:

1. Simple expression by the arms of an assistant encircling the patient's abdomen, a method met with in Africa, India, South America, rarely among the prairie Indians of the northern part of that continent, who find the task too laborious, in Polynesia, and even here and there in the British Isles. It was well known in ancient and mediæval Rome, ancient Greece, and among the Hebrews.

2. In more difficult cases a bandage is passed around the body, and tightened by assistants. Where such treatment is adopted, it is usual to make strong traction in the intervals between the pains. The descent of the child

being regarded as due to voluntary efforts on its part, the bandage is intended as a support, to prevent it losing foothold and slipping back into the abdomen.

Such a method is employed in Mexico, Finland, and Northern India.

In some parts of Central Africa a bandage having been applied to the patient's abdomen, a strong man takes the ends, rests his feet on the patient's hips, and pulls back with all his weight and strength.

In Darfur the woman lies flat on the ground, a broad belt is stretched across her abdomen, under the feet of two assistants, and then the ends are pulled by numerous sturdy neighbours. A modification of this method is met with among the natives of the middle Congo; the woman kneels in an almost prone position with a belt around her abdomen, the ends of which are fastened to a long stick, which is then twisted round and round, so that great force is thus applied.

In Senegal and some other parts the midwives sit or jump on the abdomen of the sufferer to hasten on labour.

3. Among the Winnebago Indians the patient leans face downwards, with the upper part of her stomach resting on a rope stretched taut across the hut, and over this she is gently pushed by her female attendants, some degree of pressure on the uterine fundus being thus exerted.

4. In really desperate cases the parturient is slung up in the air by bands beneath the arms, another band is fastened round the abdomen, so that its ends are nearly parallel to the uterine axis, and then one, two, or as many women as are necessary, hang with all their weight on to these. When a sufficient force is applied, something is bound to give way, and if the fetus does not travel along the natural path, it must escape through the abdominal wall. Statistics as to the success of this procedure are unfortunately not available.

5. An effective method adopted in some parts, notably in the Philippine Islands, is to stand upon the abdomen of the patient with the heels upon the thorax, the toes pressing upon the fundus uteri, and thus express the child.

6. A belt which is gradually buckled tighter and tighter is in use among the Sioux.

7. Among the Crows, Creeks, and the Negritoes, of Micronesia, it is customary for the woman during the second stage of labour to lean with the uterine fundus pressed against a stick firmly embedded in the ground.

8. In Loango and some other parts of the West Coast of Africa the parturient is placed face downwards over a log which presses upon the abdomen, and expulsion is hastened by the onlookers either trampling or placing heavy weights on her back.

Means are taken among some peoples to soften and dilate the perineum. In Central Africa it is a routine practice for any woman in whom rigidity of the soft parts is suspected as a cause of lingering labour, to squat or lean over a fire

of leaves, so that the hot air and smoke may act on the perineum. In America the medicine man smokes a large pipe, and blows large clouds of smoke between the thighs of the parturient. In Siam the patient lies roasting before a hot fire. In Annam definite means are taken to dilate the vulvar orifice; the midwife sits in front of her patient, and with both her great toes presses back the perineum, while with her index fingers she pulls apart the labiæ.

Stretching of the perineum is also employed by Dakota squaws, who endeavour to separate both hands, introduced palms outwards into the vulvar orifice.

Undoubted midwifery forceps have been found in tombs of an early date in Egypt, and similar instruments are known to have been used in Japan long anterior to the advent of European civilisation. It is interesting to note that, although the instruments of both countries were made with quite orthodox cephalic curves, the perineal curve had either not been discovered, or its advantages were not appreciated.

The rarity of accidents among many savage tribes is really extraordinary, considering they have really no means of meeting them, and serious malpresentations such as the transverse must necessarily be fatal, save perhaps in Uganda, where Cæsarian section has been performed by native operators, with good results both to mother and child. Some Indian tribes consider that, delivery being due to voluntary efforts on the part of the fetus, any obstruction is an indication of a bad character on its part, and so it is better that mother and child should perish together than that so villainous an offspring should grow up to injure his family and tribe.

The commonest accident following delivery is hæmorrhage, which is frequently treated by an abdominal shower-bath of cold water, or by suddenly ducking the patient in a stream.

Prolapse and inversion are treated by shaking the patient violently in the inverted position, and sometimes by attempts at manual reposition.

In almost all countries it is customary for mother and child to bathe or be bathed directly after delivery, and, in consequence, we find the banks of a convenient stream to be the place most often selected for confinement. The baths may be continued daily throughout the puerperium. In Upper Silesia it is customary to pour warm water over the patient's abdomen. Many American Indians take steam or vapour baths for several days after confinement. In Siam it is customary for the woman to expose her naked abdomen and back to the rays from a fire only two feet distant from her, and kept blazing continuously day and night. To this torture they are put for a period varying from seven to thirty days. In Cambodia endurance is tested still further, and the patient rests on a couch of bamboo lattice work directly over the fire, fully exposed to the purgatorial smoke and heat. Among the Apaches and many other

tribes the woman is kept on her feet walking about for a long period each day, to favour a free lochial discharge, rest in the horizontal position being regarded as harmful.

The European binder has its representative among savage tribes, but with them it is applied only to the abdomen, and not over the hips.

The lying-in period seems to vary from nothing, among many peoples who return to work after the bath completing the confinement, to thirty days or more in Siam. The ancient Greek women used to rest at home thirty-three days after the birth of a boy, and sixty-six after the birth of a girl. The Samoyede woman remains isolated for several months after childbirth, and during this period is almost completely neglected. Up to a few years ago, for the first three days of the puerperium, Japanese women of all save the lowest classes were compelled to sit bolt upright in a stiff chair, and were not even allowed to let their head bend forwards or backwards; as a consequence they suffered very severely from the resulting insomnia, but there is no evidence that puerperal insanity was more common among them than among other races with less barbarous customs.

In most countries but little attention is paid to the diet of the puerperal woman in the first few days after her confinement, but a few interesting customs exist. Among the Swahili the food is highly seasoned with pepper; the Loango women drink vast quantities of water to increase the flow of milk, while the Rasuto woman is allowed no water at all for three days to prevent over-distension of the breasts. Among the tribes of Northern Siberia it is customary to almost starve the unfortunate puerpera, possibly because it is too much trouble to procure her food.

In most parts of the world the newborn child receives a foretaste of pleasures or troubles to come in the shape of a cold bath, after which it is variously greased or powdered and wrapped up. In Southern India it is usual to at once put the child to the breast; in the Andamans a neighbour who is suckling nurses the newborn infant until the mother's milk appears, while among the Kalmucks the babe is given a piece of raw mutton to suck until that event occurs. Other tribes wait until the mother's milk is available. Most savage women seem to suckle their offspring at regular intervals daily. The time of weaning varies considerably; as a rule it is delayed until the maternal milk supply fails; indeed, in some parts of West Africa it is not uncommon to see children of very different ages taking the breast at the same time. In southern India, among the more primitive tribes, three to five years, and in Australia one to three years, are the rule. Arabs nurse for two years, and the Tartars and Esthoniens until succeeding confinements compel the women to attend to their younger offspring. For the purpose of weaning the child from the breast various unpleasant tasting substances are placed on the nipple, myrrh and asafoetida in Arabia,

aloes in Somaliland, and cayenne pepper in Zanzibar. In some parts of southern India it is customary to give the infant a dose of castor oil every day or every other day for the first three months.

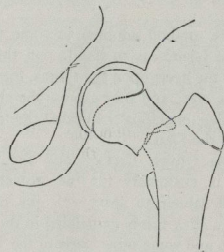
On the whole, from a brief survey of primitive midwifery one is driven to the conclusion that savages have very much neglected this important subject, and fail to show the resource and ingenuity they exhibit in connection with the other departments of medical science.

### Fracture of the Neck of the Femur in a Boy of Thirteen.

By T. A. MAVO, M.B., F.R.C.S.

**I**N August of last year a boy of thirteen was admitted into the Hospital, under the care of Mr. Walsham, in an unconscious condition, with the history of a fall off the banisters of a staircase on to some stone paving below. He was found to have concussion of the brain, and further examination revealed eversion of the right foot, crepitus over the right hip, two inches elevation of the trochanter, relaxation of the deep fascia over the hip, and rotation of the trochanter round a small circle. There were no marks of bruising over the trochanter. The limb was put up with a long Liston's splint, 9 lbs. extension being found necessary to overcome the shortening. This was maintained for seven weeks, a skiagraph being taken at six weeks confirming the diagnosis, and showing the fragments in fair but not accurate position (see Fig. 1).

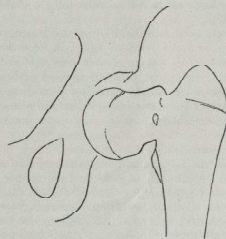
FIG. 1.



The boy was kept in bed two weeks longer, and massage and passive movements were employed. Half an inch of shortening was noted, and the various movements at the hip-joint could all be carried out, though limited owing to the stiffness of the muscles and adhesions. For a fortnight he got about on crutches at Swanley, and then walked with the aid of two sticks eleven weeks after the injury. He

was then lost sight of, but coming up seven months after the injury, he now displays evident traumatic coxa vara. He cannot run, but walks fairly well, with a limp on the right side. The right leg is adducted, the trochanter is elevated an inch, and is prominent, the outward thrust being three quarters of an inch more than that of the left trochanter. There is one inch wasting of the thigh in circumference. Flexion is somewhat limited, also inversion and eversion equally. Adduction is free, but abduction almost quite limited. A skiagraph shows the condition in Fig. 2. There is no pain on examination, but he has chronic pain in damp cold weather.

FIG. 2.



Much interest attaches to fractures of the neck of the femur in children and adolescents, both on account of the resulting progressive deformity, and on account of the fact that it is only within the last decennium that the comparative frequency of the fracture has been admitted, chiefly owing to the work of Whitman of New York. He pointed out that the supposed frequent separation of the upper epiphysis of the femur in young children is almost always a fracture of the neck, and that the separation of the epiphysis is rare, and only occurs in adolescents in whom there is a less resistant periosteum and a weaker epiphysal junction. Radiography has now confirmed this. In young children up to seven or eight the fracture is usually only partial or greenstick, not entailing immediate helplessness. There is some eversion and shortening up to three quarters of an inch, this being due to the soft condition of the young bone and the thick envelope of periosteum and recurrent capsular fibres round the neck. The depression of the neck caused by the accident increases as the child uses its leg, and leads to painful limping, and the diagnosis of tuberculous disease by the unwary.

In this case of a boy at thirteen the fracture was complete, partially intra-capsular probably; and from the large amount of shortening—to wit, two inches—the fracture must have completely involved the above protective covering, or at any rate must have considerably detached it. This periosteal covering is thick and strong at thirteen years,

and for some years later. Despite the extent of the injury, and the fact of its being partially intra-capsular, good union took place—the common result in young subjects. The position of the fragments, however, was faulty, and explains the subsequent increase in the depression of the neck, and the elevation of the trochanter a further half-inch. There is a natural diminution of about 30° in the angle at which the neck meets the shaft from early age upwards to adult life; and if this angle is lessened by an injury the body-weight then acts at an undue advantage on the young growing bone, and leads to undue depression. Comparable to this is the bending at and near the lower epiphysis of the femur and the upper epiphysis of the tibia that sometimes takes place after excision of the knee-joint in young subjects, if care is not taken to maintain the union of the tibia and femur at the angle agreed upon, for some months after the operation by a fixed apparatus. If the above theory were true, it follows that if in this case the deformity had been exactly reduced, the strain of the body-weight after firm union had been established would have acted along the original pressure lamellæ, and no further depression beyond the normal have ensued. But on account of the effusion of blood in the capsule, and the plastic inflammatory swelling following on the injury, it was impossible to appose perfectly the fractured ends by extension, though 9 lbs.—as much as could be borne—was employed, and the shortening apparently overcome by measurement. Restoration of the angle was thus practically impossible, and in this way was comparable to the condition in Pott's fracture, where a functionally perfect result with regard to the after-use of the ankle-joint rarely occurs except in the slight cases and in those successfully wired. This is due to the effusion and plastic inflammation causing the surrounding muscles and deep tissues to bulge outwards, to shorten, and thus resist extension.

The skiagraph (see Fig. 2), as far as it can be trusted, shows that the bending has taken place at the line of fracture, and at the expense of the lower part of the distal fragment of the neck, which has atrophied apparently from pressure absorption, Fig. 1 showing no such change six weeks after the injury. Further increase of the deformity can be prevented, but it entails a traction hip-splint and crutches for some months; otherwise a cuneiform osteotomy at the level of the small trochanter to restore the angle is the only alternative. A perfect result after the fracture has not been recorded, and probably never will without operation. The best results are in cases of partial fracture in younger subjects.

I am indebted to Mr. Walsham for permission to publish the notes of this case.

The diagrams are line reproductions from skiagraphs taken in the Electrical Department of the Hospital.

## On Goitre.

A Paper read before the Abernethian Society, on Thursday, February 28th, 1901, by T. P. LECC, F.R.C.S. (Surgical Registrar and Tutor, King's College Hospital.)



R. PRESIDENT AND GENTLEMEN,—I propose to consider goitre in its clinical aspects. To understand the effects produced by goitre one must know the anatomy of the thyroid gland. The thyroid gland consists of a right and left lobe, one on each side of the trachea, and a narrow portion, the isthmus, lying in front of the second, third, and fourth rings of the trachea. From the upper part of the isthmus, a slender process, the pyramid, passes upwards towards the hyoid bone. This process is not constant. The whole gland is enclosed in a capsule, and it is connected with the larynx and trachea by fibrous tissue. Passing from the upper border of the isthmus to the lower part of the thyroid cartilage and front of the cricoid is a band of fascia forming the anterior ligament of the gland. Each lobe is about two inches long and one and a quarter inches wide. The isthmus is about half an inch wide, and from a quarter to three quarters of an inch in depth. The thyroid is covered in front by the infra-hyoid muscles; the sterno-mastoid overlaps it on each side. The common carotid artery is behind and to the outer side of each lobe. The trachea, lower part of the pharynx, and oesophagus are on the inner side of each lobe, the left slightly overlapping the oesophagus.

The arterial supply is derived from, first, the superior thyroid, which enters the gland at the apex of each lateral lobe, and divides into three branches; anterior, posterior, and external. Second, the inferior thyroid, which passes to the posterior surface of the gland at its lower end.

There are three sets of veins: the superior and middle thyroids, which enter the internal jugular, and the inferior, passing to the left innominate vein. The veins are large, have thin walls, and when empty may be easily mistaken for fascia. They become greatly enlarged in certain forms of disease. The inferior laryngeal nerve is behind each lobe, lying between the oesophagus and the trachea; the sympathetic cord is placed behind the sheath of the common carotid. Occasionally one or more accessory thyroids are present; they may become diseased like the thyroid itself.

Enlargement of the thyroid may be due to the growth of adenomata, parenchymatous change, and malignant disease. I shall say nothing about exophthalmic goitre.

By an adenoma is meant an encapsulated tumour growing in the thyroid, and having a structure similar to the gland. Three common varieties are met with: the fetal, the solid, and cystic. There is a fourth rare variety, called the malignant adenoma.

(1) *Fetal adenomata* are usually found in children and young adults. They resemble in structure the normal fetal thyroid; on section they are solid and have little or no colloid. They are very vascular, and when operated upon may bleed very freely.

(2) *Adenomata and Cystic Adenomata*.—These two varieties may be taken together, as the cystic is a result of degeneration of a solid adenoma. They constitute the majority of goitres. On section they may appear solid, and are composed of a soft, pale, red, gelatinous material; distinct cysts may be present, sometimes quite small, and other times forming the whole tumour. Intermediate stages are often found, the tumour being partly solid and partly fluid. Their structure resembles normal thyroid, but the connective tissue is somewhat more abundant, and the vesicles more irregular. The fluid in the cysts varies in colour from a light yellow to a dark brown in old cases, where there has been some hemorrhage into them. Cholesterol is frequently present, and the crystals can be seen floating on the surface of the fluid.

All adenomata have a great tendency to undergo secondary degeneration. They frequently become cystic and form thyroid cysts. If these cysts are examined, traces of growth are seen on the walls as soft, friable masses, which are liable to cause hemorrhage into them, and may give rise to serious symptoms. Bleeding may take place into the interior of a soft adenoma, causing rapid increase in size and dyspnoea. Fibrous degeneration is common in long-standing cases. If the surface of such a tumour be examined, it will be found to be opaque, tough, and is readily distinguishable from the surrounding gland. Moreover, such an adenoma, whether cystic or

solid, shells out of its capsule more easily than the young adenomata, which are soft and friable, and not so easily distinguished from the gland.

In old adenomata patches of calcification are found, but they are of no clinical importance.

Innocent adenomata having reached a certain size remain unchanged for a long period, or for the rest of a patient's life, causing no symptoms. The rate at which they grow is very variable. (3) Malignant adenomata are rare. They recur after removal, and reproduce themselves in distant parts.

*Parenchymatous goitre*. By this term is meant an increase in size of the whole gland. Both lobes are affected, but not to the same degree. The general shape of the gland is preserved. All the elements of which it is composed are hypertrophied. There is, however, a relatively greater increase in the amount of colloid material, and on section this is readily seen. It is not uncommon to find parenchymatous goitre containing adenomata embedded in its substance. In some cases these can be felt as rounded lumps in the tumour. If they are deeply seated and not palpable, the diagnosis may be made clear by the administration of potassium iodide, and iodine, with thyroid extract. These drugs diminish the size of the parenchymatous goitre, but have no effect on adenomata, which will therefore become more evident.

*Malignant disease of the thyroid* is not uncommon. It generally occurs in people over forty years of age. It does sometimes occur in younger patients, as in a young man who was in the Royal Free Hospital, under Mr. Berry, in July, 1890, and who was twenty-five years old. Both sexes are nearly equally affected, and both sarcoma and carcinoma occur, the former being either spindle-celled or rounded. All the cases which I have seen have been spindle-celled. The disease generally runs its course very rapidly, on an average in six to eighteen months.

CASE 1.—A woman aged fifty-five years had a small swelling in her neck since childhood; it gave her no trouble till November, 1898, then it began to get larger, and she had slight shortness of breath. In March, 1899, the swelling was as big as a large orange, hard, and lobulated, and extended as high as the thyroid cartilage and as low as the sternum. In April, 1899, it had ulcerated through the skin, and she died in July, 1899, about nine months after the goitre began to grow.

CASE 2.—A man aged twenty-five was admitted to the Royal Free Hospital, in July, 1899. Three months before admission he noticed a lump the size of a walnut on the left side of his neck. Till July it grew slowly; in the fortnight previous to his admission it had grown rapidly; he had had some dyspnoea at night and some huskiness of his voice. A large tumour was found on the left side of the thyroid, displacing the trachea to the right, and the larynx was beneath the right angle of the lower jaw. The mass was hard and nodular, fixed to the surrounding structures, and moving slightly in swallowing. He could only speak in a whisper, the left vocal cord was completely paralysed, and he had much pain on swallowing. The dyspnoea rapidly got worse, and on July 28th tracheotomy was done. By August 20th he had got much thinner and weaker. On this date he had a severe hemorrhage through the tracheotomy tube, and another on the 30th, when he died, about five months after the tumour had been first noticed.

CASE 3 illustrates an important clinical fact—that an innocent goitre may become malignant. A goitre which has remained for a long period of the same size, beginning to rapidly increase in size, should always raise the question of malignant growth, especially if the patient is getting on in life.

The more important signs of malignant goitre are these.

(1) Rapid increase in size. This may be due to two other changes, (a) hemorrhage, (b) inflammation. A parenchymatous goitre may rapidly increase at puberty and cause severe symptoms. (2) Hardness and lumpiness of the surface. (3) Pain in the neck, passing to the shoulder, and dysphagia; neither of these symptoms is usual with innocent tumours. (4) Fixity to the trachea, and especially to the pharynx and surrounding muscles. This leads to loss of mobility, but the growth may become adherent to the trachea and pharynx, and still move with swallowing, and yet be beyond the reach of complete removal. (5) Involvement of the great vessels of the neck; these can be traced to the upper part of the growth, and are then lost in it. In an innocent goitre they are merely displaced. (6) Paralysis of the inferior laryngeal nerve, shown by immobility of the vocal cord on the affected side; and unequal pupils, from paralysis of the sympathetic. Examination of the larynx may show that the growth has penetrated the trachea. (7) Involvement of the skin, unless punctured, is uncommon; the lymphatic glands

are not much help in the diagnosis; they may be quite unaffected.

Secondary growths may occur in the lungs, and the bones are liable to become the seat of secondary carcinomatous growths, some of these reproducing the structure of the thyroid itself. Death is usually due to exhaustion, dyspnoea, septic bronchitis, or pneumonia, especially if tracheotomy has been performed.

The clinical signs of an innocent goitre are these,—a tumour situated in the region of the thyroid, covered by the sterno-mastoid, and moving up and down the neck with swallowing. A parenchymatous goitre preserves the general shape of the gland. The tumour is globular if it is an adenoma. The effects produced by a goitre depend on the pressure it exerts on surrounding structures. Many adenomata produce no symptoms at all. A small adenoma which is situated low down, becoming impacted in the upper opening of the thorax, may produce violent dyspnoea by its pressure on the trachea. A large tumour high up in the gland, and growing forwards, frequently gives rise to no symptoms of dyspnoea. Pressure on the trachea is the most important effect of innocent goitres. A parenchymatous goitre exerts a bilateral pressure on the trachea, which becomes narrowed at the point of pressure, but it remains in the middle line of the neck. A large adenoma or cyst pushes the trachea to the opposite side of the neck. The position of the larynx and the trachea should always be determined, as an aid to the diagnosis in a doubtful case.

A tumour springing from the isthmus, or lowest part of the lateral lobe, and lying in front of the trachea, will not cause much dyspnoea, as the pressure is borne by the rings of the trachea, which are highly elastic. It should be remembered that many tumours apparently connected with the isthmus are really springing from the lateral lobe.

Dyspnoea is the most frequent result of thyroid tumours, and manifests itself by the patient complaining of shortness of breath, by huskiness of cough, and stridor on drawing a deep breath. It is the great indication for operation. Sudden dyspnoea is due to the tumour becoming impacted in the upper opening of the thorax, hemorrhage, or inflammation in it. It also occurs with parenchymatous goitres which increase rapidly at puberty.

Another effect of pressure is the displacement of great vessels of the neck, which can be felt along the outer and posterior border of the tumour throughout its whole length.

The inferior laryngeal nerve is not affected by innocent goitre; therefore laryngoscopic examination of the larynx shows nothing, except the displacement (if it is present) of the larynx or trachea.

The main points in the diagnosis of the varieties of goitre have been indicated in the foregoing description. It is sometimes difficult to distinguish a large adenoma or bilateral adenomata, from a parenchymatous goitre.

The chief points are the shape of the tumour, which is globular in adenomata, and the preservation of the normal shape, with a notch between the two halves, in the parenchymatous, which is seldom so markedly lobulated as in multiple adenomata. Great inequality of size suggests the presence of an adenoma in the larger half. It is important to distinguish between the two forms, as the treatment of them is different. It is very often impossible to say whether an adenoma is cystic or solid. This is quite unimportant, as the treatment is the same in each case, viz. enucleation.

There are two methods of treatment: (1) medicinal; (2) operative. The former is applicable to parenchymatous goitres, and has practically no effect on an adenomata. The drugs which are of the most use are thyroid extract, beginning with a small dose, grs. 2, *per diem*, increasing it, if necessary, the local effect and constitutional symptoms being watched; and a mixture of potassium iodide and t. iodine, three times daily,—5 minis. of the latter, and 5 grs. of the former; the amounts of each being increased, as required, till 15 or 20 grs. of the iodide, and the same number of minims of the tincture are being taken. The goitre will diminish in size, and it is useful to treat cases prior to operation in this way, so as to lessen the size of the tumour, and make the operation easier. The indications for operations are, (1) dyspnoea, (2) increase in size. It is questionable, whether deformity alone is a sufficient indication for operation. A large goitre, which is an inconvenience to the patient, may be removed; and a small one, if it is steadily growing, especially if the patient is going to some distant place, beyond the reach of a surgeon.

I shall say nothing about tapping cysts, and the injection of the various fluids which have been used. It is not a method of treatment which is reliable, and it has distinct drawbacks.

There are two chief methods of operating: (1) Enucleation, *i. e.*

shelling out the tumour from its capsule, and applicable to adenomata. (2) Extirpation,—the removal of one half of the gland, with its capsule; this operation is therefore extra capsular. It is a more serious operation than the former.

Two incisions are used—the transverse, low down in the neck, and the oblique, along the anterior border of the sterno-mastoid muscle. The transverse gives less room, but has the advantage of placing the scar out of sight, and in a comparatively short time it becomes almost invisible. The oblique scar often shows up prominently, and has a tendency to undergo keloid thickening, becoming hard and rigid. The oblique incision should be used in doing the operation of extirpation, and generally when the tumour is very large, but some surgeons use a transverse or slightly curved incision for all cases.

The sterno-mastoid is drawn outwards, and the infra-hyoid muscles are either divided high up or drawn aside. Now, suppose the tumour is to be enucleated; on reaching the thyroid its surface is examined and palpated, a spot is chosen over the tumour where there are no vessels, an incision is then made through the gland till the capsule of the tumour is reached, which is then divided. The tumour is shelled out by a blunt instrument or the finger, and any hemorrhage is arrested. The capsule and the rest of the wound, including the infra-hyoid muscles, are sewn up without (very frequently) a drainage-tube. If the transverse incision has been used, the platysma and deep fascia should be united by two or three sutures, otherwise the wound is liable to gape after removal of the stitches.

The most important points in the performance of this operation are—

(1) Strict Asepsis; strong antiseptic lotions should not be used to flush out the wound.

(2) Hemorrhage, which may be considerable, especially if the tumour be large, solid, and soft, so that it breaks up during removal. Any vessel wounded in cutting down on the tumour is at once clipped, and the wound kept as dry as possible. Most of the bleeding occurs during the actual enucleation, and after the tumour has been removed. The former may be diminished by rapidity in operating, and can be checked at the end of the enucleation by sponge pressure, or by inverting the capsule by seizing it with forceps and bringing it out of the wound. Any bleeding vessel is then clamped and tied.

(3) The tumour is recognised by its colour, which is a bluish or yellowish-white, thus differing from the gland, which is reddish. There is always a layer of gland tissue over the tumour; it may be so thin that the tumour is seen as soon as the gland is exposed; it must always be divided before the capsule is reached, and the enucleation can be performed. In recently formed tumours the growth may come away in pieces. If a cyst is present it may be ruptured, thus allowing it to be more easily removed.

The advantages of enucleation are—(1) it is a comparatively easy operation; (2) no gland tissue is removed; (3) the inferior laryngeal nerve and other important structures are not likely to be damaged; the nerve should not be seen.

Extirpation is a more difficult and serious operation. As far as the exposure of the gland, the steps are the same as in the previous operation, it will generally be advisable to divide the infra-hyoid muscles. The finger is gently pressed all round the gland so as to lightly lift it from its bed. The superior thyroid vessels are then sought for at the apex of the tumour, and divided between two ligatures. The lateral veins are next ligatured. These vary in number, but each must be carefully exposed and tied before being divided. The tumour will then lie free on its outer side. It is turned forwards and inwards, and the inferior thyroid vessels are sought for at the lower and posterior part of the tumour. They are often very large; the artery may be tied before it breaks up into its branches, or these may be tied separately. It is at this stage that the nerve is likely to be damaged, this is avoided by keeping close to the gland and picking up the vessels very carefully. Very often the nerve is not seen, and need not be looked for. The isthmus is now divided; several vessels usually require ligaturing on its cut surface. Division of the fascia passing to the trachea from the gland completes the operation. A large cavity is left in the neck, at the bottom of which is seen the carotid artery and jugular vein, and on the inner side the trachea, which is often flattened by the pressure of the growth. The size of this cavity may be diminished by two or three purse-string sutures passed through its walls, a drainage-tube being used for the first twenty-four hours. This is not required in every case, but when there is much oozing, and size of the cavity can not be lessened by suturing, it is advisable to put one into the deepest part of the

wound to prevent the blood accumulating and distending the wound.

The immediate dangers of this operation are:

(1) Hemorrhage. Owing to the large size of the veins and their thin walls, which when stretched appear like bands of fascia, a large amount of blood may be lost if they are not carefully clamped or ligatured before being tied. When this is done the hemorrhage is slight.

(2) Dyspnoea. To diminish the risk from this complication the head must be held quite straight in the middle line, and a careful watch kept on the breathing, especially when the tumour is turned forwards and inwards.

(3) The planes of fascia in the neck are widely opened up; therefore great care must be taken to prevent the wound becoming infected.

The remote dangers are sepsis and hemorrhage, both of which are preventable. If a sinus should result, it is often very persistent and difficult to heal, otherwise it does not cause much inconvenience.

After the operation the patient is generally more comfortable if he is propped up in bed, with the head somewhat inclined forwards. He is generally able to get up on the fourth day, in some cases as early as the second day. The stitches are removed on the fourth or fifth day. By this time the wound is quite healed, and unless a drainage tube has been used, it will not need to have been dressed. Restlessness and vomiting are early troublesome symptoms; the former should be treated by sedatives, and the latter by abstinence from all food and liquids for the first twelve hours by mouth, and then only in small quantities at stated intervals.

Incisions, varieties.

As regards operations for malignant goitre, it is only in the early stages, before the disease has penetrated the capsule, that they can be successful. Many operations, which have been undertaken on apparently movable tumours, have been incomplete, because the tumour has been found fixed to the trachea or pharynx. Tracheotomy is frequently required, on account of dyspnoea. Before doing this operation the position of the trachea must be determined, and the incision made over it. It may be necessary to cut through or remove part of the growth before opening the trachea. A special form of tube, called Keenig's, is required. It is much longer than the usual kind, and is made of a spiral coil. Sepsis is a great danger after the operation, and the patient does not usually survive long; the longest case that I have seen live about a month; another case lived six days; a third two days; and fourth died the next day after the operation.

The division of the isthmus for the relief of dyspnoea demands a brief notice. If the effects of a goitre on the trachea are considered, it will be seen that this operation can rarely have any effect in relieving it. The proper way to treat dyspnoea is by removal of the cause, whenever this is possible, the exception being malignant disease.

The last point I want to direct your attention to, is the question of an anæsthetic in goitre operations. An anæsthetic greatly increases the risk of the operation when dyspnoea is present. By using eucaïne, 4 per cent. solution, or  $\frac{1}{4}$  gr. cocaine, locally, the dangers of a general anæsthetic are obviated. About 30 to 60 mins. of the solution of eucaïne are required to produce local anæsthesia, the injections being made at several points along the line of the incision. It takes a few minutes to act, and the effects last a considerable time. All that the patient usually complains of is the dragging on structures of the neck. Very large goitres can be removed with ease and safety by this method.

## Two Cases of Ovarian Tumour with Symptoms of Intestinal Obstruction; Operation; Recovery.

By C. A. S. RIDOU, M.R.C.S., L.R.C.P.



HOUSEWIFE, Z. D.—, æt. 47, was admitted into Lucas Ward on April 3rd, 1901, under care of Mr. Langton, for vomiting, constipation, and distension of the abdomen.

History of present condition.—Patient's last menstrual period occurred nine months ago, the previous two or three having been copious and attended with pain. Two months later the abdomen was noticed to become swollen. A medical man

was consulted, and he tapped her abdomen then and on four subsequent occasions, telling her that she had a tumour which ought to be removed, but this the patient refused. The last tapping took place on March 31st, 1901, and a considerable quantity of fluid was removed; her bowels were also opened on that day. The patient says that her abdomen did not become flat after this last tapping, but remained swollen. On April 1st patient vomited two or three times, and also on April 2nd. During these three days the bowels were not moved, and enemata were returned with but very slight result. On April 3rd, at 1.30 a.m., patient came to the surgery, and was admitted.

Past history.—Married; no children.

Family history.—Unimportant.

Condition on admission.—Patient looks ill; her face is thin, pale, and anxious; tongue furred, moist; temperature 96°; pulse 100, small and weak; respiration 20; chest very poorly covered, according to her own account she has been wasting much of late; urine 1020, acid, no albumen, no sugar.

Abdomen.—Markedly distended; coils of distended intestine plainly visible through abdominal wall; free fluid can be detected. On palpation a mass is felt occupying the right iliac fossa, reaching above almost to the level of the umbilicus, and extending obliquely across the hypogastric region into the left iliac fossa; its consistency is firm, its upper limit fairly well defined, its outline nodular, below it is lost in the pelvis; the mass is fairly moveable, not markedly tender; skin natural over it, and not adherent to it; percussion note is dull.

Per vagina.—A firm mass is felt through the anterior wall, apparently identical with the above.

The patient vomits frequently, the vomit being feculent in character; constipation absolute; two enemata were returned, one with a slightly coloured result, per rectum; nil abnormal felt.

Patient was taken to the old theatre at 1.30 on April 3rd, and chloroform was administered. Mr. Langton made an incision through the linea alba, below the umbilicus, five inches in length. On opening the abdominal cavity a gush of ascitic fluid; a large solid tumour was found occupying the right iliac fossa; this was discovered to be connected with the left ovary, and extending between the layers of the broad ligament on the left side; its pedicle was found twisted, thus accounting for the position of the tumour. The mass itself was sloughing at its upper extremity and covered with flakes of lymph; it was bound down by firm adhesions to surrounding gut, and there were evidences of recent peritonitis. The tumour was freed from its adhesions, its pedicle transfixed and ligatured with stout silk, and the mass removed. All bleeding having been arrested, the wound was closed with silk-worm-gut sutures, the peritoneal cavity having been previously sponged and irrigated with sterilised water; a Keith's drainage-tube was left in Douglas's pouch through the lower end of the wound.

Patient was much collapsed after the operation, which lasted one hour and a quarter. Oij of saline solution were infused into the veins of her arms, and her pulse again became perceptible. She remained, however, in a very critical condition until early on April 4th, when she rallied considerably. Four-hourly nutrient enemata containing brandy ʒss were administered.

After progress quite satisfactory. Keith's tube replaced by rubber tube April 5th, the latter being removed April 6th. The abdominal wound healed except where the tube had been inserted, at which point there was a little suppuration. Patient complained of pain in left iliac fossa, where a firm small mass could be felt. There was incontinence of urine and feces.

April 17th.—Temperature rose to 101.2°; on the 18th to 101.6°; on the 20th to 102.4°.

22nd.—Patient has passed two stools containing mucus and much altered blood. The mass in the left iliac fossa is scarcely perceptible now.

23rd.—Patient continues satisfactory. Temp. *sib* average.

The case was one of exceptional difficulty owing to the firm adhesions of the tumour to surrounding intestine, and to the peritonitis present; also to the fact that there was no distinct pedicle, the growth extending into the left broad ligament. The condition of the patient previous to operation was very poor, and the injection of Oij of saline into her veins seems to have been the means of saving her life.

E. J. W.—, æt. 29, housewife, was admitted into Lucas Ward under care of Mr. Langton, February 27th, 1901, suffering from symptoms of intestinal obstruction.

H P C., Feb. 26th.—Patient had sharp pain in right side of abdo-

men after taking two pills the previous night, and putting mustard and water to the feet; she also vomited on February 26th.

Condition on admission.—Abdomen distended, tense, painful to touch in right lumbar region, no tumour felt; temp. 101°; resp. 28; pulse 100.

Treatment.—Rest and milk diet.

Progress.—March 1st: vomited twice, passed flatus; temp. 101°. March 7th: better. March 16th: left hospital, all symptoms having subsided; but a small tumour was felt in right iliac and lumbar regions.

Diagnosis.—Inflamed ovarian cyst.

Patient came to the surgery on Tuesday, April 8th, and was re-admitted into Lucas on April 11th, having suffered no further trouble.

Condition on admission (April 11th).—Patient is a very stout but healthy-looking woman; tongue clean; bowels not open; pulse regular, and of good volume and tension.

Abdomen pendulous. Occupying the right lumbar, umbilical, and iliac regions is an elastic tumour of the size of a small football, well defined, superiorly, externally, and internally, where it almost reaches the umbilicus; below it sinks into the pelvis; skin is natural, not adherent; percussion note is dull; the tumour moves freely; transverse measurement of tumour 10 inches.

Menstrual history.—Periods regular until last child was born; since then have been irregular.

Operation.—Abdominal section was performed by means of a median incision five inches in length in linea alba. On opening peritoneal cavity a large cystic tumour was found connected with the right broad ligament, to which it was attached by an elongated pedicle; the cyst was punctured, and a large quantity of dark gummy fluid was evacuated; the cyst wall was dark in colour, friable, and necrotic, and very adherent to surrounding intestines, which bore traces of old and recent peritonitis. With some difficulty the cyst wall was freed from its adhesions, the pedicle transfixed and ligatured with stout silk, and the tumour was removed. It was found to be a necrotic ovarian multilocular cyst, the pedicle having become twisted. Diced pieces were seized, the pelvis sponged out, and a Keith's drainage-tube was inserted into Douglas's pouch. The wound was then closed.

Progress. Satisfactory except for persistent vomiting, which lasted thirty-six hours. Patient did well, except for slight suppuration at lower end of wound, until the night of April 22nd, when she felt pain upon coughing, and on examination some gaping of the upper part of the wound was found. Bowels have been freely opened, and her condition has remained quite satisfactory up to the present (April 23rd).

This case is interesting in that the symptoms of obstruction passed away although the cause was not removed. In the first case the symptoms became very severe; in both cases the pedicles twisted, though the one was a solid, the other a fluid tumour.

## Ibernetian Society.

### ANNUAL GENERAL MEETING.

THE Annual General Meeting of the Society was held on March 21st, Mr. Gask in the chair.

The minutes of the last meeting having been approved, Mr. Murray and Mr. Scholberg were elected scrutineers, and retired to count the votes.

A letter from Mr. Willett resigning the office of Treasurer to the Society was read by the Secretary. Mr. Willett's resignation was accepted with great regret, and a motion put from the chair that he be accorded a vote of thanks for his long past services to the Society was carried with unanimous emphasis. The question of Mr. Willett's successor was, after some discussion, left to the Committee.

The audited accounts for the past year were submitted to the meeting and passed.

The Annual General Report was then read by the Secretary and passed unanimously.

Some discussion about the better management of the reading-room then ensued, it being finally determined to leave this matter also in the hands of the Committee.

The meeting terminated with a vote of thanks to the retiring officers, to which Mr. Gask made suitable reply.

### REPORT OF THE COMMITTEE FOR THE SESSION 1900-1901.

Your Committee have much pleasure in presenting their Report for the session 1900-1901.

They deeply regret having to record the death of Mr. Vernon, for many years a Trustee of this Society, which took place so recently.

In October last Mr. Enstace Talbot was obliged to resign the office of President owing to ill-health. Mr. J. A. Nixon was elected to fill the vacancy.

Your Committee view with great pleasure the increased interest taken in the proceedings of the Society during the past session. The average attendance at the ordinary meetings has been sixty, as against thirty-three during the previous year. This good result is to be explained not so much by abnormally large attendances at the sessional and mid-sessional addresses as by an increased average attendance at the other ordinary meetings. Over a hundred members have attended three or more meetings, and are entitled to take part in the election of officers. Twenty-eight new members have been admitted to the Society during the past year.

Consequent on the Report of the Committee of last year a Special General Meeting was held on October 4th, 1900, to receive the recommendations of the Sub-Committee on the revision of the Laws of the Society. Since this date the revised Laws of the Society have been printed.

At an ordinary meeting held on March 7th a motion proposing that smoking be allowed at ordinary meetings of the Society was passed.

The School Committee were approached, and expressed their willingness to grant their permission for one year.

An enlarged photograph of the late Mr. Vernon has been hung in the Society's room, and arrangements are being made to get one of the late Professor Kanthack.

The sessional address in July of last year was delivered by Sir Dyce Duckworth, that in October by Mr. Bowly, and the mid-sessional address in January by Mr. Butlin.

Twelve papers have been read before the Society, one by a member of the senior staff, one by a former member of the teaching staff, two by former members of the junior staff, five by members of the teaching staff, and three by other members. Two of these papers were illustrated by lantern slides.

Five clinical evenings have been held. These have been most successful, many of the cases and specimens shown being of great interest and rarity. Accounts of these meetings have been published in the Hospital JOURNAL, as well as abstracts of all the papers, some of them having appeared *in extenso*.

The Society has a balance at the bank of £29 os. 2d.

### OFFICERS FOR THE YEAR 1900-1901.

Presidents.—Mr. W. S. Danks, Mr. F. C. Shrubbsall.  
Vice-Presidents.—Mr. N. E. Waterfield, Mr. N. MacLaren.  
Secretaries.—Mr. H. J. Slade, Mr. T. J. Faulder.  
Additional Committeemen.—Mr. A. K. Neigan, Mr. V. C. Upton.

## Pseudodoxia Epidemica Moderna.



COUNTRY life leaves leisure, and especially a country life in winter in Ireland. It was a tempestuous afternoon; a biting north-east wind was blowing up the lake from the Atlantic, bringing furies of snow with it. It seemed a good afternoon to sit by a warm fire. I took down

Sir Thomas Browne's 'Pseudodoxia Epidemica,' and ensconced myself in a comfortable easy chair. With this old book I said to myself, "I will forget the winter and the wind and snow outside; I will even forget the modern world, and go back three centuries into that pleasant time when there was leisure for learning, even if it was useless, and a man who set himself to it could really take all knowledge for his portion." I opened the old folio, and read of many things, how—

"That an Elephant hath no joints."

"That a Pigeon hath no gall."

"Of the generation of Toads and of the Stone in their heads."

"That the Ostrich digesteth iron."

"Of the Providence of Pismires in biting off the ends of corn."

In fact, I read on and on until the early twilight dimmed the page, and the letters swam before my eyes. I closed the book, and began to wonder what Sir Thomas would discuss if he were alive now.

The firelight danced on the walls, thoughts of tea and buttered muffins gently floated across the senses, and for a moment—only for a moment—my eyelids dropped their shade.

The next moment I felt a tap on my arm, and started up. Before me stood the figure of an elderly man, dressed in the fashion of King Charles's time, of moderate stature, "neither fat nor lean, but *susarbas*." His hair was brown, a gentle blush mantled on his countenance, and he looked with an eye of complaisance on the volume at my elbow. Under his arm was another volume something like it, and of enormous fatness. It could be no other than Sir Thomas Browne himself. I rose from my chair, and making a profound bow, said, "If I mistake not, the immortal author of the 'Religio Medici.'"

"Young man," said the Shade, "it rejoiceth me to know that the Iniquity of Oblivion hath not blindly scattered her poppy, and that a large part of me hath yet withstood the tooth of Time."

"Why, Sir Thomas," I said, "your writings are not only the glory of our profession, but one of the chief boasts of the English language. The stately prose of the 'Religio Medici' and the 'Hydriotaphia'—"

"Tush!" said the Shade, "these be but youthful imaginings. It is on more ponderable works that I would fain base my omission from Forgetfulness. Doubtless the 'Pseudodoxia Epidemica' are yet in the mouth of all learned men."

"Well," I said, "you see scientific things so soon become out of date. The discoveries of one generation become the common-places of the next. We do not occupy our minds much nowadays with the jointless state of elephants or the Providence of Pismires. If the work now could be brought up to date—"

The Shade looked at me significantly and laid the volume he was carrying on the table. "My leisureable hours," said he, "have not been vainly wasted while that the Elysian Fields have claimed my spirit. This little volume containeth the disquisition on more than 15,000 vulgar errors of these modern times. Fain am I that these labours be not wasted, that the learned may have the fruition of this opuscula. He that had the printing of my works hath long since passed the mortal barrier. To you, young sir, I would confide this treatise, since it becometh me the time is now ripe for it."

I gazed at Sir Thomas with some dismay. "What publisher," I thought, "will embark upon this venture? How can I soothe the author for his wasted labours?"

I looked into the fire and tried to form some tactful utterance, when the door opened, and the pleasant clash of teacups assailed my ears. I looked up. The Shade had vanished, but not the opuscula, which lay upon the table, bending it with its weight.

Since that day I have looked much into the work, and have selected of the 15,000 flowers of learning two or three which seem particularly to concern ourselves. Here are some of them—

#### THAT AN EXAMINER HATH NO BOWELS.

This is a notion very common among young students and him that hath not yet quitted his Alma Mater. St. Thomas Aquinas and the Ancient Schoolmen have nicely reasoned that in Paradise the just have no bowels, and Pontoppidan also hath it that the bear and pig have no bowels and need none, but that examiners should have no bowels seemeth contrary to reason. It is open to all men that they have bowels both from their natural motions and the disorders that attend them, and before one becometh an examiner he must become a man. On the other hand, it hath been affirmed, though with what reason we know not, that an examiner is peradventure sometimes just, and with more reason that he is a bear and a pig. Yet is he a bear or a pig only as it were by a pleasant trope or conceit of fancy which liketh his manners to those of these animals. It followeth not therefore that the Creator hath fashioned his inward parts conformable also to those of a bear or a pig.

The oracles of Scripture moreover have added to the confusion. For such sayings as "bowels of compassion," where bowels are used for heart rhetorically, hath confused the student, who is ever diligent in Holy Writ. It would seem then that the dictum "An examiner hath no bowels," hath arisen from a topical or loose saying, that it hath no foundation in nature and is contrary to reason.

#### THAT TO THE SURGEON HOUSE MIXTURE IS THE UNIVERSAL BALSAM OR MITHRIDATE.

It hath even been the vain hope of man, that even as the alchemist would convert all metals into gold, so might he find the Universal

Potion, which would purge all humours. Who hath not heard of Mithridates his Treacle, or King Solomon his Balsam? It had been left to these latter times and to those who have ever been regarded by Physicians as Pretenders in the realm of medicine to vaunt themselves that they have found the Cure-all or Theriacum, which not even Solomon in the height of his glory could discover. Hath a patient the gripes or colic; House Mixture! Hath he a flux; House Mixture! Hath he a stoppage of the bowels; House Mixture! Is his blood heated; House Mixture! Is it cooled; House Mixture! Hath he drunk too freely of strong waters; House Mixture! Hath he been too abstemious; House Mixture! Hath he broken a limb; House Mixture! Has his limb by their meddling surgery to be broken; House Mixture! Are his wits clouded; House Mixture! Are they too nimble; House Mixture.

And so through all the realms of medicine their pervagation affordeth them no other treacle.

Yet hath this Chimæra no foundation in original knowledge or in Inductive Learning, but cometh, as the spider spinneth his web, as it were out of their own bowels.

The Physician who hath dived more deeply into these Arcana or inward secrets of the body knoweth that the discovery of such a treacle is indeed a vain hope; but he appointeth, as the learned Munyon hath laid down, to each disease its remedy. Here a purging ball, there an electuary; to another a conserve, to a fourth a balsam, and so through all the realms of medicine dividing unto each severally the Mithridate perfect thereunto. It is our hope, therefore, that these meddling surgeons will no longer break like wild boars into the vineyard of medicine, but will root and grovel without in the places hedged off for them from the foundations of knowledge.

#### THAT SPIRIT TAKETH THE CHILL OFF WATER.

There hath long been a notion abroad, and more especially among the female or weaker half of creation, that spirit, aqua vite, Holland rum, or what not, is not only qualifieth or altereth water when added thereto, but doth actually cause coction or heating of the same. What Physician is there that hath sat at the receipt of custom, or rather the place whence he dispenseth his wisdom, but hath had some such parley or colloquy as the following:—

There cometh to his table a mother in Israel, as the Psalmist David hath it.

"Madam," saith he, "and what drinkest thou?"

"Sir," saith she, "nothing passeth my lips save water."

"'Tis but a poor fluid on which thou thrivest so mightily," saith he.

"Sir," saith she, "as I am a living soul, nothing passeth my lips save water with just a drop of something to take the chill off."

At that the physician looketh at his Alumni and smileth gently. The cheeks, nay, peradventure, the nose, of the lady telleth plain to all that there is no chill within.

Any that hath that new physician's toy, the heat measurer, may prove that the spirit taketh not the chill off water, or that it is cold without. Where, then, lieth the mystery?

The answer to this rebus taketh not the wisdom of Solomon, and to him that inwardly digesteth as well as readeth, lurketh in one of the pithy sayings or apothegms of Hippocrates, which runneth as follows:

"He that would keep his spirits up must even pour spirits down." Now the application of this oracle to the present case is on this wise. When the water qualified with spirit entereth the lady's gullet, the vital spirits, which, as Descartes saith, are concocted in the stomach and heart, do rise up to meet the spirit in the water, thereon ensueth a great battle, spirit fighting against spirit for the mastery, the one chasing the other through all the orifices, bowels, apertures, veins, and by-ways of the body. Now, where is contention for the mastery, there also is sweat, heat, and vexation. Hence ensueth a coction of the blood, which poureth red hot and in such a torrent through the lady's veins that a gentle warmth permeateth all the tissues; yet hath the spirit not taken the chill off the water but the lady. This pseudodoxia then ariseth from a confusion of subject and object, and hath more of reason in it than the error of Cambyses' potion.—*St. Thomas's Hospital Gazette.*

P. S. H.

## Notes.

MR. A. BOWLEY, F.R.C.S., and Dr. Tooth have been appointed Companions of the Most Distinguished Order of St. Michael and St. George, in recognition of their services with the troops in South Africa.

DR. CALVERT has been appointed Lecturer in Materia Medica, Pharmacology, and Therapeutics.

MR. E. W. BREWERTON, F.R.C.S., has been appointed Ophthalmic Surgeon to the Metropolitan Hospital, and Pathologist and Curator of the Museum at the Royal Westminster Ophthalmic Hospital.

DR. COLLINGRIDGE, Medical Officer for the Port of London, has been appointed Medical Officer of Health to the City of London.

J. C. NEWMAN, M.R.C.S., L.R.C.P., has been appointed Junior House Surgeon to Mr. Langton, *vice* F. E. Brunner, M.B., who has resigned on account of ill-health.

R. A. DUNN, M.D., has been appointed Medical Officer of Health to the Hertford Combined District.

SIR DYCE DUCKWORTH, M.D., has resigned the appointment of Lecturer in Medicine.

MR. HOWARD MARSH, F.R.C.S., has resigned the appointment of Lecturer in Surgery.

THE Lectureship in Anatomy is rendered vacant by the resignation of Mr. C. B. Lockwood, F.R.C.S.

DR. HORDER has resigned the post of Editor of the JOURNAL. During his term of office, which has been no short one, he has earned the gratitude of all our readers, and by his efforts and untiring energy has succeeded in maintaining for the paper a standard not unworthy of the Hospital.

THE Jacksonian Prize for 1900 has been awarded to Mr. McAdam Eccles for his essay on "The Pathology, Diagnosis, and Treatment of the Diseases caused by, and connected with, imperfect descent of the Testicle."

ON Tuesday, April 2nd, a Deputation from the Matrons' Council of Great Britain and Ireland was received at the War Office by Lord Raglan, Under-Secretary of State for War, when the President, Miss Isla Stewart, presented a Report in writing embodying the views of the Council on

the subject of the reforms required in the organisation of the Army Nursing Service.

The principle which the Matrons' Council has consistently maintained, and which is embodied in its Report to the Secretary of State for War, is that the Army Nursing Service and the Army Nursing Service Reserve should be, both in times of peace and war, directly under the control of the War Office, in connection with which a Nursing Department should be created with a trained Superintendent of Nurses in charge, who should be held responsible for the control, discipline, and efficiency of the members of the Army Nursing Service.

The long and short of this recommendation is that the selection, training, and organisation of Members of the Army Nursing Service, must, like that of all other professions, be placed in professional hands. A wider application of this principle is a worthy end to strive after, and it is to be hoped that the views of the experts will in this instance carry weight.

THE Annual View Day will be held this year on May 8th. We understand that there will be no Dinner this year on account of the death of Her late Majesty Queen Victoria.

THE Past 7. Present Cricket Match will be played on Wednesday, June 13th, at Winchmore Hill. The Secretaries will be glad to hear of any Old Bart.'s men who can play in the match.

THE Musical Society has begun practising for the Summer Concert, which will take place in the third week of June. It is hoped that any members of the Hospital who can sing or play in the Orchestra will lend their support, and not allow their modesty to cloak their ability.

BISHOP CORFE is anxious to obtain a Resident Medical Officer for a Mission Dispensary at Chemulpho, Korea. Terms—£100 a year with Board and Lodging.

It has been proposed that a Memorial Tablet to the late Mr. Vernon should be erected in the Hospital Church as a tribute from his former House Surgeons. Notice will be sent by post later. If by any mischance these should fail to reach their destinations, it is hoped that any Old House Surgeons who may see this notice will communicate with Dr. Attlee, 58, Brook Street, W.

**Amalgamated Clubs.**

BALANCE-SHEET, 1899-1900.

To Members' Subscriptions ... ..	£. s. d.	By Grants to Clubs:	£. s. d.	£. s. d.
„ Grant from Medical School ... ..	668 17 0	Rugby Football Club ... ..	18 10 0	
	100 0 0	Association Football Club ... ..	15 13 6	
		Boxing Club ... ..	22 0 0	
		Shooting Club ... ..	14 7 10	
		Swimming Club ... ..	17 7 0	
		Lawn Tennis Club ... ..	11 18 0	
		Hockey Club ... ..	5 16 0	
		Cricketer Club ... ..	30 5 0	
		Athletic Club ... ..	43 2 0	
		Boating ... ..	12 0 0	
			191 0 4	
Audited and found correct according to vouchers and bank pass-book.		By Abernethian Society, 76 members at £1 1s. ... ..	79 10 0	
H. MORLEY FLETCHER.		„ Musical Society ... ..	20 0 0	
L. B. RAWLING.		„ Maintenance and Reserve Fund ... ..	450 12 7	
ALEX. R. TWEEDIE.		„ Loss on the JOURNAL ... ..	27 8 1	
	£768 17 0		£768 17 0	

**MAINTENANCE AND RESERVE FUND.**

To Balance from 1898-9 ... ..	£. s. d.	By Kent of ground ... ..	£. s. d.
„ Funds as per General Account ... ..	272 2 3	„ Rates, Taxes, and Water ... ..	300 0 0
„ Sale of Refreshments (account not rendered).	450 12 7	„ Coal, etc. ... ..	42 18 1
		„ Refreshments, etc. ... ..	12 2 0
		„ Wages of ground-men and boy, keep of horse, and general maintenance of ground and pavilion.	15 3 9
		„ Dairy, Past v. Present ... ..	130 10 1
		„ Cheque Books ... ..	5 5 0
		„ General Secretary's petty cash ... ..	0 8 4
		„ Wages of clerk ... ..	13 0 0
		„ Repairs to Pavilion ... ..	3 0 0
		„ Repairs to Pavilion ... ..	18 5 6
		Balance at bank ... ..	179 13 1
Audited and found correct according to vouchers and bank pass-book.			£722 14 10
H. MORLEY FLETCHER.			
L. B. RAWLING.			
ALEX. R. TWEEDIE.			
	£722 14 10		

**CRICKET CLUB.**

At a general meeting of the above Club held in the Smoking-room on October 11th, 1900, the following officers were elected for the ensuing year:

**President.**—Sir William Church, M.D.  
**Captain.**—C. A. Anderson.  
**Secretaries.**—C. F. Nicholas, G. G. Ellett.  
**Captain 2nd XI.**—C. H. Fernie.  
**Secretary 2nd XI.**—L. Chambers.  
**Committee.**—H. E. Scoules, L. Orton, H. E. Stanger-Leathes, W. S. Nealon, H. B. Hill, H. T. Wilson, G. H. Adam.

The following is the list of fixtures for the coming season.

Date.	Opponents.	Ground.
Sat. May 4	Trial Match	Winchmore Hill
Sat. „ 11	Mr. H. E. G. Boyle's XI.	Henley
Sat. „ 18	Henley-on-Thames	Winchmore Hill
Wed. „ 22	Enfield	Winchmore Hill
Sat. „ 25	Richmond	Winchmore Hill
Sat. June 1	M.C.C.	Winchmore Hill
Sat. „ 8	Waldegrave Park	Winchmore Hill
Wed. „ 12	Past v. Present	Winchmore Hill
Sat. „ 15	Addlestone	Addlestone
Sat. „ 22	Danet	Winchmore Hill
Wed. „ 26	Hornsey	Hornsey
Sat. „ 29	Dunstable Grammar School	Dunstable
Wed. July 3	East Molesey	East Molesey
Sat. „ 6	Hampstead	Hampstead
Sat. „ 13	R.I.E.C.	Cooper's Hill
Sat. „ 20	Surbiton	Surbiton

The Secretaries will be glad to hear the names of any Old Bart's men who wish to play in the Past v. Present on June 12th.

**SECOND XI. FIXTURES.**

Date.	Opponents.	Ground.
Sat. May 4	Trial Game	Winchmore Hill
Sat. „ 18	London Hospital 2nd XI.	Winchmore Hill
Sat. „ 25	University School (Old Boys)	Winchmore Hill
Wed. „ 29	St. Thomas's Hospital 2nd XI.	Winchmore Hill
Wed. June 5	Royal School of Mines	Winchmore Hill
Sat. „ 8	St. Thomas's Hospital	Chilswick
Sat. „ 15	Guy's Hospital 2nd XI.	Winchmore Hill
Wed. „ 19	Blackheath School	Blackheath
Sat. „ 22	Claybury Asylum	Claybury
Sat. „ 29	Hospital Employees	Winchmore Hill
Sat. July 6	London Hospital 2nd XI.	Lower Edmonton
Wed. „ 10	Guy's Hospital 2nd XI.	Honor Oak
Sat. „ 13	Banstead Asylum	Banstead
Wed. „ 17	Merchant Taylors' School	Winchmore Hill

**HOCKEY.**

The Hockey Club concluded their list of fixtures on March 23rd, when they defeated Norwood by 3 goals to nil. On the whole the season has been fairly successful. Out of a total of 25 matches played, 12 were won, 8 lost, and 5 drawn; 12 other matches on the card had to be scratched from various causes. Though the number of successes did not reach that of the previous season, this is partly accounted for by the fact that stronger teams were met; also there was a great difficulty in getting a representative team together to play regularly, especially during the first half of the season. As a

general rule the club did its best against the strongest teams, while in many of the other matches the play was very scrambling and devoid of combination. In the Inter-Hospital Competition Bart's defeated Middlesex and Guy's, but were beaten by London Hospital in the final tie by 2 goals to 1, after a very keen and fast struggle.

The forward line has been greatly handicapped by the frequent changes that have taken place, notably among the "insides." In hardly a single instance did the same forwards do duty in two consecutive matches. The shooting, on the whole, was not a strong point, the goals obtained being 75, as against 57, by our opponents. The halves and backs played more regularly, and there were more men to fall back upon in case of necessity than in the case of the forwards.

It is to be hoped that more men will take up the game next season so that a second team can be started. If sufficient support is given matches will be arranged.

**THE UNITED HOSPITALS' HARE AND HOUNDS CLUB.**

**TEN MILES CROSS COUNTRY CUP COMPETITION.**

**Conditions.**—Any number to run, three men from each hospital to count.

The above race was run on March 16th over the Blackheath ten miles' course, which, owing to previous rains, was in a heavy condition, and promised to speedily find out those competitors who had not trained carefully. Such conditions, however, argued well for the success of our representative, J. G. Gibb, who is a runner of exceptional experience and stamina, the only competitor at all likely to lower his colours being A. C. Birt, of St. Thomas's, who had trained thoroughly, and looked very "fit." Three hospitals competed.—Guy's (holders), St. Thomas's, and St. Bart's. Quite a large field, numbering about 15, faced the starter, and this number would have been considerably increased had not Bart's experienced such singular ill-luck in being deprived through illness, etc., of five of our original team, viz.:—P. Goss, B. N. Ash, H. E. Graham, F. Gibb, and F. S. Lister; in fact, it was only the sportsmanlike endeavours of A. C. Wilson, J. R. Trist, and H. N. Wright (who ran practically untrained), that enabled us to put a team in the field.

The result of the competition was a win for St. Thomas's with 10 points; St. Bart's being second, with 12; and Guy's third, 23.

**The Race.**—From the start Gibb and Ditt went to the front and quickly established a long lead, which was further increased as the race proceeded, none of the other competitors being able to get on terms with them at any part of the race. At seven miles Birt was leading Gibb by 100 yards; the latter, however, finished the last three miles with his usual vigour and, gradually wearing Birt down, eventually won very easily by 130 yards, Birt, in turn, being about 300 yards in advance of G. H. Simmons (St. Thomas's), W. H. Barnett (St. Bart's) was fourth. The result of the competition now lay between St. Bart's and St. Thomas's, the next man in deciding it, F. D. Cochrane (St. Thomas's) filled this position, and so enabled his hospital to beat us by the narrow margin of two points. A. C. Wilson finished seventh, and ran very well considering his untrained condition (G. H. Simmons, with three minutes' start, won the seized handicap, W. H. Barnett, whose handicap was also three minutes, being second).

**Starter and Timekeeper.**—H. W. E. Sarcombe.

**Judges.**—Dr. H. A. Munro, W. Rowland, E. Ratcliff.

From the above it will be seen that St. Bart's were very unlucky, and, all things considered, to be beaten by two points only was a very meritorious performance.

A word of thanks is due to the Blackheath Club, who not only laid the trail, but also provided two judges.

	Order of Finishing.		Order in
	Start.	Hep.	
1 J. G. Gibb (St. Bart's) .....	—	—	65.8
2 A. C. Birt (St. Thomas's) .....	scr.	65.53	3rd
3 G. H. Simmons (St. Thomas's) 3 min.	—	66.21	1st
4 W. H. Barnett (St. Bart's) .....	3	64.48	2nd
5 H. D. Cochrane (St. Thomas's) 3	—	68.47	71.47
6 A. E. Blyne (Guy's) .....	3	73.4	75.4
7 R. C. Roper (St. Bart's) .....	—	—	76.21
8 H. P. German (Guy's) .....	4 min.	75.18	79.18
9 R. S. Roper (Guy's) .....	3	77.32	80.32

Also ran.—R. Larkin (Guy's), J. R. Trist, and H. N. Wright (St. Bart's).

**BOAT CLUB.**

The Boat Club, which was revived last year, is now in a flourishing condition. Two fours will shortly make their appearance at Putney, and there is a good prospect of pulling off both Senior and Junior events in the Inter-Hospital races, which are arranged to take place on the afternoon of Tuesday, May 21st. Payne, Etherington Smith, Gould, and Slade will probably represent us in the Senior Four, Phillips being unable to row for the Hospital owing to his being up at Oxford during the summer. Noke will, no doubt, get together nearly as good a crew for the 2nd Four out of the excellent material at his disposal, such men as Graham, Levick, Hudson, Arnould, Statham, and several others of equal fame being available.

One of the greatest difficulties in getting together a hospital crew is the finding of a cox, suitable men of a reasonable weight being scarce. It is hoped that this difficulty will be satisfactorily overcome.

This year probably the same hospitals will compete for the Inter-Hospital Cup as did last year, viz.: The London, George's, Thomas, and Bart's. On that occasion the London won by three-quarters of a length, Bart's being second, and the other two some way behind.

Several people have urged entering a four at Henley. The chief objection to this is the great expense. It would probably cost about £150.

It is hoped that it will be possible to bring off a successful Club Regatta this year towards the end of May. The races proposed are: Handicap Sculls, Tub Pairs, and Scratch Fours. It is hoped there will be good entries.

A dressing-room and boats for practice are provided at Putney, and any members can use them free of charge on signing their names in a book kept there for the purpose. Any further information may be obtained from the Hon. Sec.

The following are the officers for the coming season:

**President.**—Mr. Bruce Clarke, F.R.C.S.

**Vice-President.**—Dr. Lewis Jones.

**Captain.**—R. B. Etherington Smith.

**2nd Captain.**—F. G. Noke.

**Hon. Sec.**—H. N. Gould.

**Committee.**—J. E. Payne, J. G. Slade, W. V. Wood.

**SWIMMING CLUB.**

The following water-polo matches have been arranged for the coming season:

Date.	Opponents.	Place.
May 17	Ealing	Ealing
„ 18	Cambridge University	St. George's Baths
„ 23	South London Harriers	St. George's Baths
June 1	Cambridge University	Cambridge
„ 8	Oxford University	Oxford
„ 10	Richmond	Richmond
„ 12	South London Harriers	Clapham
„ 19	Richmond	St. George's Baths
„ 21	Ealing	Ealing
„ 26	Oxford University	St. George's Baths
July 3	London Scottish R.V.	St. George's Baths

**Headquarters.**—St. George's Baths, Buckingham Palace Road, S.W.

Meetings for races and water-polo practices are held at St. George's Baths on Wednesdays at 4 p.m. and it is hoped that men wishing to swim or play water-polo, especially freshmen, will attend these meetings as often as possible.

Cheap tickets for admission to the baths can be obtained either from the Hon. Sec. or from the cloakroom attendant.

C. DIX, Hon. Sec.

**Correspondence.**

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

**AFRICAN CIVIL SURGEONS' DINNER.**

Sir,—A desire has been generally expressed by men recently serving as civil surgeons in South Africa to hold a dinner. Derby Day, Wednesday, June 5th, the anniversary of the occupation of Pretoria, is suggested for the purpose. It is proposed to include all civilian medical men, whether attached to the R.A.M.C. or to private hospitals. Sir W. MacCormac has consented to preside.



and the following have already expressed their intention of being present.—Mr. Makins, Prof. Chiono, Mr. Watson Gheyne, Mr. Cheate, Sir Wm. Thomson, Mr. Bowly, Mr. Fripp, and Dr. Tooth.

The following provisional committee has been formed.—Mr. Anthony Bowly, Chairman of Committee; Messrs. C. S. Wallace (St. Thomas's) and F. Houseman (St. George's); Dr. A. Conan Doyle (Edin.), and Messrs. J. F. R. Gardner (Glasgow and Leeds) and E. L. Hunt (Dublin).

We shall be glad to receive suggestions at the following address, and hope to publish details at a later date.

We remain, Sir, yours faithfully,

C. GORDON WATSON (Bart's).

F. E. FREMANTLE (Guy's).

Acting Secretaries.

39, Moore Street, Lennox Gardens, S.W.:  
April 27th.

### Calendar.

May, 1901.

Wed.	May 1	—Summer Session begins.
Fri.	" 3	—Sir William Church and Mr. Willett's duty.
Tues.	" 7	—Dr. Gee and Mr. Langton's duty.
Fri.	" 10	—Sir Dyce Duckworth and Mr. Marsh's duty. Sir William Church's Clinical Lecture at 1 p.m.
Sat.	" 11	—Cricket v. Mr. H. E. G. Boyle's XI. at Winchmore Hill.
Mon.	" 13	—Examinations for Brackenbury Scholarships begin.
Tues.	" 14	—Dr. Hensley and Mr. Butlin's duty.
Wed.	" 15	—Mr. Willett's Clinical Lecture at 2.45 p.m.
Thurs.	" 16	—Ascension Day.
Fri.	" 17	—Sir T. Lauder Brunton and Mr. Walsham's duty. Dr. Gee's Clinical Lecture at 1 p.m. Swimming Club v. Ealing, at Ealing.
Sat.	" 18	—Examination for Lawrence Scholarship begins. Cricket v. Henley-on-Thames, at Henley. Swimming Club v. Cambridge University, at St. George's Baths.
Tues.	" 21	—Sir William Church and Mr. Willett's duty.
Wed.	" 22	—Mr. Willett's Clinical Lecture at 2.45 p.m. Cricket v. Enfield, at Winchmore Hill.
Thurs.	" 23	—Swimming Club v. South London Harriers, at St. George's Baths.
Fri.	" 24	—Dr. Gee and Mr. Langton's duty. Sir Dyce Duckworth's Clinical Lecture at 1 p.m.
Sat.	" 25	—Cricket v. Richmond, at Richmond.
Tues.	" 28	—Sir Dyce Duckworth and Mr. Marsh's duty.
Wed.	" 29	—Mr. Marsh's Clinical Lecture at 2.45 p.m.
Fri.	" 31	—Dr. Hensley and Mr. Butlin's duty. Examination for Matthews' Duncan Medal. Dr. Hensley's Clinical Lecture at 1 p.m.

### Examinations.

UNIVERSITY OF CAMBRIDGE.

D.P.H.—J. G. Forbes, H. A. Scholberg.

Pharmacy.—L. W. Geraty, C. W. C. Harvey, L. V. Thurston, W. V. Wood.

Elementary Biology.—R. A. Dowling, P. H. W. Brewis, H. D. W. Bund, R. V. Favell, W. R. Favell, J. G. Gibb, W. H. Harvey, G. P. Jones, P. Lang, J. R. Lloyd, W. G. Loughborough, R. C. P. McDonagh, C. B. Mora, E. H. Shaw, H. C. Waldo, J. G. Watkins, H. F. Webb-Bowen, F. Whitby, A. C. Wilson, H. N. Wright, A. C. Wroughton.

Second Examination.—Anatomy and Physiology.

J. G. Atkinson, G. D. Drury, F. M. Gardner-Medwin, H. E. Graham, M. F. Grant, W. H. Hamilton, W. C. F. Harland, N. C. Patrick, A. N. Wade, A. S. Williams, R. G. Williams, K. S. Wise.

### Conjoint Board.—First Examination.

Chemistry.—A. K. Armstrong, R. C. P. Berryman, F. H. W. Brewer, G. J. Eady, E. W. D. Hardy, T. A. Killby, H. J. S. Kimbell, E. S. Marshall, T. O'Neill, E. W. M. Paine, H. C. Waldo, E. L. Wright, H. N. Wright, A. C. Wroughton.

### Appointments.

DUNN, R. A., M.D., D.Hy.(Durham), appointed Medical Officer of Health to the Hertford Combined District.

HOWARD, VINCENT, has been appointed Deputy Coroner for the Winslow Division of Bucks, and Public Vaccinator for the 2nd District of the Buckingham Union.

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

WATERHOUSE, RUPERT, M.B.Lond., L.R.C.P., M.R.C.S., has been appointed Resident Medical Officer to the Royal United Hospital, Bath.

### New Addresses.

BURROUGHS, J. H., 39, Churchfield Mansions, Hurlingham, Fulham, S.W.

CAMMIDGE, P. J., Bacteriological Laboratory, The County Hall, Wakefield.

CHAVE, T. ANSTEE, 19, Windsor Esplanade, Bute Docks, Cardiff.

COMPTON, T., The Green, Godstone, Surrey.

DUNN, R. A., Bengoe, Hertford.

GREEN, G. E., Walliscote Lodge, Weston super-Mare.

GILL, S. E., 26, Mansfield Road, Nottingham.

GREENWOOD, F. R., 21, St. George's Square, Portsea.

KINGDON, J. A., Nelson Street, Lynn.

MARTIN, T., Thatcham, Newbury, Berks.

OVLES, O. W., 108, Uttoxeter Road, Longton, Staffs.

ROBERTSON, F. W., Ravenstone, Lingfield Road, Wimbledon.

ROBBS, C. H. D., 25, Castlegate, Grantham.

WITHERS, F. E., The Manor House, Horncastle.

YELD, R. A., 17, Platt's Lane, Hampstead, N.W.

### Births.

COURT.—On March 21st at Hambledon, Hants, the wife of E. Percy Court, M.R.C.S., L.R.C.P., of a daughter.

HOWARD.—On April 10th, at 5, West Street, Buckingham, the wife of Vincent Howard, M.R.C.S., L.R.C.P., of a daughter.


### Marriage.

FARMER—ROWLAND-RICHARDSON.—On April 16th at St. Bartholomew's Church, Southsea, by the Rev. C. P. Calvert, M.A., of St. Jude's, Southsea, W. Henry Farmer, M.R.C.S., L.R.C.P., to Lydia Constance, daughter of the late Col. C. Rowland-Richardson (late commanding H.M. 76th Regiment), and of Mrs. Rowland-Richardson, Hillborough Crescent, Southsea.

### Death.

LEVISON.—Hugo A. Levison, M.D., beloved son of Sophia Levison, after a short illness, on Sunday morning, March 17th. Funeral from 44, West 35th Street, Tuesday, March 19th, 9 o'clock a.m. Incineration Fresh Pond, L. I. Please omit flowers. London, Berlin, Mannheim, San Francisco (Cal.) papers please copy.

# St. Bartholomew's Hospital



## JOURNAL.

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### NOTICE.

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

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

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

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

### St. Bartholomew's Hospital Journal,

MAY, 1901.

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

### An Introductory Lecture on Ophthalmic Medicine and Surgery.

Delivered on May 6th, 1901. By W. H. H. JESSOP,  
F.R.C.S.

**S**INCE we met last year the Hospital and School has sustained a heavy loss in the death of Mr. Vernon, my predecessor in the Lecturership. He held the post for too short a time, and his ill-health unfortunately prevented his great and extensive clinical knowledge being more disseminated. He was a link with the greatest period of ophthalmology, when the three giants, Von Graefe, Donders, and Bowman, built up the science as

we now know it. It seems almost incredible in looking over the great clinical work done during the last half century, that the ophthalmoscope was only invented by Helmholtz in 1851, and that the first standard English work on the use of the ophthalmoscope was published by Hulke in 1861, following his Jacksonian Essay in 1859. We can imagine with what zeal Mr. Vernon joined the band of workers at the Royal London Ophthalmic Hospital, Moorfields, in 1863. Here he came from having been House Surgeon to Sir James Paget, who had imbued him with the spirit for clinical work and observation. As curator of the museum at Moorfields he perfected himself in the microscope, which for years was his delight, not only for ophthalmic work but in his leisure hours for botanical and zoological investigations.

Though he wrote little, what he did was done with great care, precision, and clearness. His papers in our 'Hospital Reports' on Congenital Myopia, Herpes ophthalmicus, Tubercle of the Eye, Intraocular Growths in Children, Iridectomy, Excision and Abscission of the Eye, are models of style. Always shrinking from publicity, he wrote no more after 1871, but devoted himself to clinical teaching.

Our Ophthalmic Department was instituted in 1869, with Mr. Power and Mr. Vernon as the first ophthalmic surgeons, and for thirty-two years Mr. Vernon worked to make it what it is now.

He had a royal memory for faces and facts, and could always recall the history of a case though he rarely took any notes and these never copious.

As an operator he was the neatest and best all-round I have ever seen. The opportunities I had of seeing him operate were some of the greatest privileges I have ever had.

He carried out the old traditions of Sir William Bowman, and no sound of talking was heard in the theatre during the actual operation. With the greatest care and apparent deliberation he would take up the instruments, and with a touch, which can only be described by the word artistic, he would fix the eye with the forceps or finger, and then

with deliberate sure cut, every movement telling, and preferably with a Graefe's knife, he would make his section, sure in doing exactly what he had set out to do.

Even to the end, when his joints were crippled with rheumatic gout, he retained this operative dexterity. As I said before, he was equally good in all operative procedure, but in his performance of simple cataract extraction, or in the more difficult removal of the capsule after cataract, he reached the highest level of operating.

I often wondered that with such manipulative dexterity he was never led to operate too much, but here came in his great judgment and self control. His one thought was for the patient, as to prognosis. Of late years he became very conservative in his surgery, and he had a rooted objection to the operation of iridectomy unless compelled to do so in a glaucoma case. In glaucoma especially his clinical observations led him to discount to a great extent the operation, especially in chronic cases. This was not from the difficulty of the operation, but from doubt in its efficacy in many cases, and belief in general treatment and in eserine.

As a clinical teacher his style and method were excellent, and it was a liberal education to listen to him sifting the facts connected with a shooting accident, which his love of sport and guns made additionally interesting.

He was a man we can ill afford to lose and most difficult to replace, and his character is best expressed in a somewhat hackneyed phrase, "nature's gentleman." No man ever endeared himself more to his medical colleagues, house surgeons, and dressers. Always a cheery nod, word, and smile accompanied his salutation.

Though no longer with us he lives in our memory as the brilliant operator, perfect clinical teacher, and true friend.

The practice of ophthalmic medicine and surgery extends back to the earliest known times, when the kings in Egypt treated their subjects medically. One of the earliest known papyri, the Papyrus Ebers, of date 1500 B.C., contains instructions for the treatment of the external and internal diseases of the eye. In fact, the knowledge of ophthalmic practice in Grecian and Roman times is little in advance of that of the Egyptians. Herodotus, however, tells us that there were specialists in his time in every branch of medicine.

In this course of lectures my object is to give you an insight into the signs, symptoms, complications, sequelae, diagnosis, prognosis, and treatment of the chief diseases of the eye, and especially in their relation to general medicine and surgery. It is in such order that I shall consider each disease. Cases illustrative of the lectures will be shown once a week in the Ophthalmic Department, so that you will thus have the further advantage of clinical work. I would specially urge you to attend these clinical demonstrations; and although it is improbable many of

you will make ophthalmology your special study, yet I would impress upon you all the great importance of devoting time to it. Do not suppose that in general practice the patient of the future will be satisfied, as in the past, with the practitioner possessing the minimum knowledge of such an important subject as ophthalmology. Remember the pitfalls are many, and you may be precipitated headlong into one of them any day in practice. In recent years I have known two or three men who have nearly lost the whole of their practice by putting atropine in an eye for supposed conjunctivitis, and thus producing acute glaucoma.

The most acute and destructive case of glaucoma I have ever seen was induced by two applications of atropine drops in a man of sixty suffering from gouty conjunctivitis. In forty-eight hours the lens had become opaque, and notwithstanding iridectomy the eye was practically lost for useful vision.

A sad case was that of a girl of six, who had iritis in the right eye with the usual circumcorneal zone of inflammation. This was mistaken for conjunctivitis, and treated actively with nitrate of silver for five weeks. The result is that the iris is completely bound down to the anterior capsule of the lens, whilst the pupil is exceedingly small, its area filled with lymph. The eye has been lost for useful vision, and the child disfigured for life. In this case a drop or two of atropine would have saved the vision and appearance of the patient.

Another drug used energetically by the laity is lead lotion, which produces, if the cornea be ulcerated, a dense white opacity on the site of the ulcer, and considerably impairs vision.

I have cited these cases to impress on you that eyes are lost for vision by ignorantly using drugs, as atropine, nitrate of silver, and lead lotion indiscriminately, when no treatment would have been followed by less trouble and better results. Many patients are only too ready to follow another patient's advice, and even treatment, and many dearly love and trust a quack. Certain public-houses in London have the reputation of supplying eye-water to their clients, and one certainly was responsible for many cases of corneal opacity, as the vaunted simple was lead lotion. An important firm of stationers did, and perhaps still do, give away eye-water early in the morning to any applicant.

I am told that England is the best market for the American patent medicines. The last I have received professes to cure weak eyes, over-worked eyes, granulated lids, lachrymation, ciliary blepharitis, etc., and, lastly, is an absorbent for cataract. One would have thought such a happy discovery as the last would have been sufficient for these drops, without their being requisitioned for ordinary complaints, as ciliary blepharitis.

How then shall you avoid making such mistakes as I have mentioned, which may happen at any moment to anyone? My one answer is by clinical work. Reading

Manuals of Ophthalmic Surgery and Medicine is absolutely useless unless at the same time you learn by clinical observation the signs and symptoms of the condition. A few hours devoted to the wards or out-patient department would soon enable you to diagnose the simple kinds of eye disease, and serve to disabuse you of such general widespread ideas as that atropine is the drug sent from heaven to be used whenever the eye is inflamed.

It is only during the last few years that the old superstition that a baby's eyes on birth should be washed with the urine of the mother has apparently died out amongst nurses and midwives.

I would ask all of you to exercise your observation clinically on eye cases, first in a wide manner, and get distinctly some fixed ideas of the physiological and then of the main pathological conditions. Look round at your fellow students in this class and see the different aspects and colours of the eyes, all, as far as I can see, normal except for occasional errors of refraction. Truly, without accurate knowledge of the physiological aspect, much ignorance may and must be displayed in medicine or surgery. The more I teach ophthalmology, the more is impressed on me the little clinical care students evince for healthy conditions. Nowhere is this more marked than in ophthalmoscopic work; the accurate diagnosis of the healthy disc takes months to learn, and yet a dresser from almost the day he has seen distinctly a pathological condition of the disc, thinks he can diagnose a healthy disc, and with the greatest confidence will append to the note of the case "optic disc and fundus normal."

From the general observation of the eye in health much may be told of the general emotions and conditions, Harvey says, "in anger the eyes are fiery and the pupils contracted." The far-away look of inattention, due to relaxation of accommodation, is shown by the dilatation of the pupils and non-convergence of the eyes. It is astonishing how the appearance of the expression is altered by the dilatation or contraction of the pupils.

In general disease we can often tell the condition of the patient by the eyes. The alteration in the transparency and polish of the cornea shown by the corneal reflex being dim; the prominence or recession of the eyeball; the size and shape of the palpebral aperture; the size of the pupil, and the quickness or slowness of its reactions. In certain diseases there are special signs, as the pupils in ataxia and allied conditions acting to accommodation and not to light (Argyll-Robertson pupils); the exophthalmos and changes in palpebral aperture and lid action in Graves's disease; the different kinds of retinitis, in chronic nephritis, leukæmia, diabetes; the changes in the retinal vessels in cases exhibiting increased arterial tension.

From naked-eye observation also certain diseases and changes in the eye may be readily diagnosed. The heavy thickened upper lid producing partial ptosis of old granular

conjunctivitis; the dull reflex of the cornea in corneal nebulae; the severe lid spasm in children suffering from corneal inflammation; the inclination of the head in paralysis of an extrinsic ocular muscle. Lastly, we have the vacant expression of the blind with the eyeball tending to turn upwards beneath the upper lid, and thus exposing more sclerotic below than usual.

Thus far I have endeavoured to place before you, in a general way, the necessity for accurate observation and clinical study, but let me impress on you that ophthalmology is the most exact of the medical sciences.

The eye from its position and ease of observation is more accessible to study and investigation than any of the other organs of special sense.

The leading men in mathematics, physics, anatomy, physiology, and pathology, have combined with the oculist and general physician and surgeon to unravel the mysteries of the eye. No part of the body has had so much careful investigation bestowed on it as the small globe, the chief axial measurements of which are under twenty-four millimetres; the constituents of which include nearly every histological element; and the refractive media of which have furnished so many problems to the physicist.

(To be continued.)

### With the China Field Force.

By H. B. MEAKIN, I.M.S.

DEAR MR. EDITOR,—The 'St. Bartholomew's Hospital Journal' has lately had so much of campaigning and battle fighting in it, that I am doubtful whether you will welcome a further supply. Still I dare say things have changed little in the short time since I was occupant of the editorial chair, and that "copy" is fairly welcome, even though it may not be exactly the kind of "copy" you would choose. This reflection is backed up by the thought that men who are coming into the I.M.S. may be glad to hear something of the life that awaits them, and I am encouraged to tell you how the Empress Dowager of China has disturbed the peaceful evenness of my life during the last six months.

Since March, 1899, my station had been Lausdowne, a Gurkha Hill Station eighteen miles up a winding hill path from the railway, with an altitude of 6000 feet, where I was in medical charge of the 9th Gurkhas and 39th Garhwalis. On June 22nd last year, as I rode back from hospital to breakfast, a telegram was handed to me ordering me to send all my Kahars (dooley bearers) and ward-orderlies to Lucknow for service in China. This, as the daily papers take some time to reach us, was almost our

first news of an expedition for China, and was soon followed by a telegram ordering me to join No. 43 Native Field Hospital at Lucknow. I got together my tent and camp kit with all the khaki I had, and started down the hill on Sunday morning, June 24th.

On the following morning I reached Lucknow. Half the hospital had already gone on to Calcutta, and the two remaining sections were to travel in a special train starting at 3.30 p.m. Lucknow seemed red hot in the June sun, coming as I had straight from the hills, and much had to be done before the hospital started. However, we eventually got the two sections into the train and started soon after 3.30. At last we could get into pyjamas and had time to study the contents of our ice-box. Wednesday morning, June 27th, saw us in Calcutta with orders to camp on the Maidan until the transports were ready to take us.

Here I must digress to speak of a field hospital, though probably, in these warlike days, with hospital scandals and commissions, there can be few who need any information as to the constitution of a field hospital. A native field hospital contains equipment for treating 100 native sick. It is divisible into four practically similar sections, lettered respectively A, B, C, and D. Each section is in charge of an officer of the I.M.S. with two native hospital assistants, who have done three years' course in one of the medical colleges in India, to assist him. A native storekeeper superintends the issue of rations. There are seven or eight doolies per section, with fifty Kahars to carry them. A Havildar, two orderlies (sepoys), a cook, two sweepers, two bhistis, a dhobi, and with any luck a carpenter, make up the establishment of one section.

Every bit of the kit of a field hospital, down to a tent peg, is carefully enumerated in a list published in the Field Service Departmental Code, and is packed in loads not exceeding eighty pounds in weight, two of which constitute the total load for one mule. The equipment includes a vast assortment of details from tents and operating tables to drugs and cornflour. The total weight of the whole hospital, including the private kit of the *personnel*, amounts to about 253 maunds (a maund is eighty pounds), and is carried by 126 mules. A fourth of this represents one section. The mules for the transport of the hospital are supplied from the Transport Department when required, but there are two "obligatory" mules under the charge of the medical officer of each section, which are part of the establishment and remain always with the hospital. These obligatory mules were increased for this campaign to three, and subsequently to seven, per section.

Each transport leaving Calcutta with troops took with it one section of a Field Hospital. I was told off with my section 43/c to the "Nairung" which carried the head quarters and one wing of the 24th Punjab Infantry. They arrived from Rawal Pindi on the evening of July 2nd, and

we sailed on the morning of the 3rd. In the few days we stayed in Calcutta before sailing there was plenty of work to do, and the weather was more than warm. I was profoundly thankful when I at last saw my section, with its *personnel* of 65 all told with twelve mules—for I was given all the obligatory mules for the four sections—safely on board ship. Here my good fortune began, for the medical officer of the 24th P.I. is Major Whitechurch, V.C., I.M.S. The last time I had seen him was when I said "good night" to him outside the Holborn Restaurant at the conclusion of a Bart.'s dinner, at which he had replied for the "Old Bart.'s Men." Few men of his rank have seen more active service than Major Whitechurch, or know more about the details of campaigning; and in addition to the pleasure of meeting an old Bart.'s man I was exceedingly fortunate in having so delightful a senior officer. During our voyage I picked up from him a great many useful hints on campaigning that very materially increased my comfort when I subsequently put them into practice.

Hong Kong was reached on Sunday, July 15th, and orders were sent on board for us to go on at once to Wei-Hai-Wei. The latest telegrams were supplied to us and told of the evil state of Tientsin. We also heard that we were gaining on the two transports carrying the 7th Rajputs—the only troops ahead of us, which had left Calcutta a few days before we did. Our anxiety lest we should arrive too late for any fighting needs no statement, but it was interesting to see how keen the men of the regiment were, and to most of them fighting was no new experience, for the 24th P.I. has seen a liberal share of fighting on the North West Frontier, and has a very high proportion of "Orders of Merit" in its ranks—a decoration given to the native troops for acts of conspicuous gallantry, and equivalent to the V.C. given to white troops.

On Thursday evening, July 19th, the "Nairung" steamed into Wei-Hai-Wei—one of the very smallest of British possessions—and again orders came to go on at once to Taku; but with them came the, to us, disappointing news that Tientsin was no longer besieged, and that the Allies had taken the native city on the 14th inst. The Legations at Peking, however, were still in the gravest danger, and we heard that an early advance of the Allies on Peking was expected.

The following evening we arrived at the outer Taku anchorage amid a unique scene. On every side were warships of every nation and every type, with hospital ships, transports, lighters, and small tugs. At night time the blaze of lights from the fleets was like that of a large town, and it was difficult to believe that we were not in harbour looking at the shore lights. The land lies out of sight, about fifteen miles from the anchorage, and the bigger ships are unable to go nearer than this to the Taku Forts. This fact, however, did not prevent one of the best of our illustrated weeklies from publishing a magnificent picture

of the bombardment of the forts by the guns of our biggest battle-ships!

There was no peace for us that night. A small light-draught steamer came alongside, and for nearly the entire night the hard work of transshipping baggage and stores went on. Tired Sepoys and Kahars hurried backwards and forwards along the alley-ways with their loads with the utmost cheerfulness. At 5 a.m. the next morning the small steamer carried us into the river, past the famous and much-battered Taku Forts, each with the flag of the nation whose troops had captured it, and past the various gunboats that had shared in the engagement. Further up the river every building had some flag flying over it, and we were told that there had been a scramble to seize everything scizable as soon as the forts were taken. I believe the British did very well in the matter of lighters, which proved invaluable when the troops began to arrive; but we by no means got anything like a "lion's share" on land, and the common story is that this was largely owing to the dearth of Union Jacks and the difficulty of making them hurriedly, while the Russian naval flag, a blue diagonal cross on a white ground, could be quickly made in any numbers. The Japanese flag is a red ball in the centre of a white flag, and the story goes that when the Japanese captured their fort the flag they hoisted was one of the white coats they wear, daubed in the centre of the back with Chinese blood.

We landed at Hsin Ho, now a busy commissariat base, but then a patch of bare country near the railway. The railway was then in the hands of the Russians. It was arranged that we should go up to Tientsin by rail the following day—Sunday,—and this we did in three separate trains, nearly all the carriages and trucks showing marks of shell and rifle fire. We reached Tientsin at about 6.30 p.m. In the train in which I travelled were Admiral Remy (American) and his staff officer, who had seen a good deal of the fighting in Tientsin, and who very kindly pointed out everything of interest as we passed. The ruins of burnt houses and villages, some still smouldering, were seen on every side, and with the exception of the Russian railway picquets not a sign of human life. The Russians had made a practice of shooting every Chinaman they saw, and there were none left to see.

At one station where a short halt was made a Russian officer who spoke Hindustani came up and chatted with the Sepoys. An Afridi asked him who had destroyed all these villages. "The Russians and French," said he, and went on to explain that there were only two important governments in the world, the Russian and French; but a howl of derision from the Sepoys, who thought his statement a huge joke and retailed it to me, prevented him from diffusing any more information of this sort among them. As we neared Tientsin broken bridges, gutted houses, wrecked and burnt railway carriages and engines,

and, lastly, the hopelessly ruined railway station, gave a picture of the devastation of war that could not easily be matched. No description could adequately picture the railway station, which had been the scene of some of the heaviest fighting. Every building was gutted by fire, holes had been punched in every wall and roof by shells, and every square foot was splashed with bullet marks. Pieces of shell lay on the ground everywhere, and little heaps of empty cartridge cases showed where each defending soldier had stood.

Our baggage was turned out on the platform, and as it was too late to move it across the river that night sentries were posted over it, while the regiment was marched to the quarters prepared for it, and I took my section to the Tientsin Club, which had been allotted for use as a hospital for the native troops. It was fairly dark by the time we marched from the station, and as we passed through the French settlement we could barely see the tottering ruins of the houses. Darkness, however, did not, unfortunately, dull one's olfactory sense, and one did not need to be told that there was something "very dead" in the near neighbourhood. The Pei Ho was still carrying its load of putrescent and half dog-eaten corpses to the sea, and the boat bridges checked them in their passage, until the friendly pole of a sentry on duty guided them gently between the boats. At another stage in the journey one passed what had been a large sugar warehouse, and this, having been fired by the Chinese shells, the building is now a ruin; but the streets and drains are choked with caramel and charred sugar, in some places lying in pools a foot deep. Stepping-stones and planks had been arranged so that it was possible to avoid wading in "toffee."

At the Club I found Sections A and B of 43 N.F.H., which had arrived a day or two earlier with the 7th Rajputs. We lived in the billiard room, our beds between the tables. These were more flies and mosquitos than I had ever known anywhere else, and the heat was as bad as any that Calcutta can boast. Our diet was chiefly bully beef and biscuits, but sometimes the luxuries of fresh meat and bread were added. Thirst was one chief trouble, and to relieve it we were dependent upon an unpleasant and unreliable water that was made more unpalatable still by boiling, and which gave most of us a sickness we christened "Pei Ho disease," because we attributed it to the water which came from the Pei Ho river. To live within continual sight of a club bar with all its suggestion of unlimited drink, with one's tongue like washleather, made one sympathetic with Tantalus, for of course the club as a club had ceased to exist, and the supplies of the bar had long since been exhausted. Later on a limited supply of whisky and aerated water became obtainable, but the price of aerated water suggested that one was drinking a "vintage wine."

In Tientsin I met Major Fooks, I.M.S., and Captain

Walton, I.M.S., both old Bart.'s men. Walton I had known well at Bart.'s, and Fooks was "in Bowlby's year," and told me many tales of that period.

The date of the advance to Pekin was announced daily as "to-morrow morning," and every night we turned in with everything ready to start; but delay after delay occurred, and it was not till the afternoon of August 3rd—Friday,—that I suddenly got orders to go out with my section to accompany the 20th P.I., who were to move a little way up the river as an advance guard.

In the meantime there was plenty to do, and the interest in watching the troops of other nationalities arrive was very great. A walk through the streets at almost any hour in the day was sure to be well repaid by some new sight, and one soon learnt the various foreign uniforms and indications of rank. Saluting and returning the salutes of others gave one no rest, and became a regular nuisance, but was some slight indication of our popularity or otherwise with our continental neighbours. At that time the German force had not arrived, but Americans, Russians, Japanese, and French swarmed in the streets, and it was apparent that our native troops were quite as full of interest to them as they were to us. The picture of the tall pipers of the 24th P.I. giving a selection of bagpipe music as they marched up and down the street outside their quarters, before a cosmopolitan crowd of diversely clothed soldiery, and the equally cosmopolitan residents in Tientsin, is one that, were I artist enough, I should certainly paint.

We rode out to see the native city that had been captured by the Allies just a week before. Corpses of Boxers were strewn about the ground and in the ruined houses, and it was no uncommon sight to see dogs fighting over them. The odour was nauseating. Every house between the settlement and the Native City was a charred ruin.

(To be continued.)

### Some Mistakes of Others.

By a G. P.

SOME of my friends have made such flattering comments on my last little contribution, that I am emboldened to enter upon the more congenial task of recording a few mistakes made by others, whom I have met in consultation or whose patients have come to me.

I speak of these with bated breath, only recording them from the sense of their great value in teaching us what to avoid or what to seek. Mistakes are the bitter necessities of experience we must pass through before becoming reliable, evenly-balanced, judicious practitioners. In a previous

paper I have attempted to classify them, and they can all be easily classified under the headings given.\* Who can doubt the value of a "second opinion" in the majority of instances? The careful attendant loses nothing; he is apt to gain experience and knowledge; oftentimes a fee, often a better opinion from his patient, and, most important of all, his patient is likely to gain. Our patients are often inclined to prefer the second opinion in the absence of their previous doctor, and if the consultant be biassed, or neither man is quite honest, such a desire is doubtless reasonable. But the majority of us are honest, and most consultants also unbiassed; they often cannot give an opinion without notes of the case, and very hard luck comes to the other doctor when his patient returns aggrieved with the illness labelled under another name, and a treatment apparently different, but essentially unaltered. Consultants who know not the past conditions are apt to forget to give due credit for care, and skill, and the peculiarities of the human mind in these matters, and so cause needless pain and ill-feeling.

M. I.—had irregular bleeding up to her sixth month of pregnancy; she had been treated for cervicitis throughout but there were the clearest signs of hydatidiform mole, which she subsequently safely passed. Some months afterwards there was a well-marked erosion that needed treatment.

T. A.—, æt. 35, had been successfully treated for pernicious anæmia with arsenic on three occasions (relapses). On the fourth occasion arsenic was pushed till symptoms—gastro-intestinal catarrh and neuritis. But unfortunately after its withdrawal these symptoms persisted and caused death. It can only be argued as an alternative to arsenic poisoning that the neuritis owned some other cause. There was a great amount of pigmentation, but no blepharitis. If arsenic, it is an example of a cumulative action.

H. C.—, æt. 37, retired naval captain, with history of syphilis, had a persistent brassy cough and interscapular lancinating pain. He was treated for pleurisy and bronchitis (both of which existed) by Pot. Iod. etc. But he had a very obvious aneurysm of aorta, which caused his death. Often we treat fairly correctly with a most inadequate diagnosis.

H. B.—, æt. 3 weeks, had pemphigus neonatorum which developed on the third day of life. The boy of particularly healthy parents, the confident diagnosis of congenital syphilis produced the greatest consternation. Yet despite profound marasmus and nasty aspect, together with diarrhoea, the child recovered with a treatment of boracic baths, Ung. Acidi Salicylici and humanised milk. There were no other presumed syphilitides, no snuffles, and the subjacent dermis was everywhere healthy and soon healed. No mercury was used. This is the second such case I have seen. The text-books very confidently assert the high probability of such early severe pemphigus being syphilitic.

\* St. Bart.'s Hosp. Journ., July, 1900.

### The Unpopularity of the R.A.M.C.

By ARNOLD W. IZARD, Civil Surgeon.



NE of the many defects of our military system, prominently brought before the public by this South African war, is the undermanning of the R.A.M.C. That this is not due to any neglect on the part of the War Office authorities is sufficiently clear from the Report issued by the Hospital Commissioners, in which they state:

"The deficiency of the staff of the R.A.M.C. before this war was not the fault of the Director-General and the staff of officers associated with him. They had for a considerable time before the outbreak urged upon the military authorities the necessity for an increase in the corps, but for the most part without avail."

Just so; the cause of the unpopularity does not lie with the officers who administer the system, but with the system itself. The time is opportune to briefly bring before your notice some of the causes, studied by one who for a whole year has been serving as a civil surgeon with the Field Force, and is therefore in a position to see what some of these causes are, and why it is that, in spite of so many free commissions being offered, so few are accepted, and why even here, when an official circular was issued intimating that the Commander-in-Chief would give twenty-five commissions in the R.A.M.C. to civil surgeons, twenty-five men out of the 500 could not be found willing to accept it. I know the physical examination and the age limit (thirty) would debar many from the service.

The facts of the undermanning are briefly these, as shown by the Commissioners' report: when 40,000 troops had left the country, the *personnel* of the R.A.M.C. was practically exhausted, yet we know 200,000 troops had to be sent out. This deficiency was met by the employment of 500 civil surgeons, by the employment of St. John's Ambulance Corps, the Colonial Ambulance Corps, the Imperial Hospital Corps, and many volunteers. It is not so much of the rank and file, but of the officers I would speak.

Many will tell you at once that why so few enter the R.A.M.C. is that the pay is not sufficient, but I would ask how many young men, in the first year of their practice, can earn more than £200 a year, and that paid regularly and with no trouble to collect. Or, again, how many practitioners, after twenty years' work, can retire on a pension of £1 a day. Of course there are the Harley Street specialists, happy are they who win the prizes in life's lottery; but there are also the rank and file. So with £200 a year to begin with, and with a pension of £365 a year after twenty years' service, it cannot be the insufficient pay, as they are financially a great deal better off than the majority of civil practitioners.

M. E.—, æt. 7, had subacute nephritis. The observation of the mother, that her child was "getting fat very quickly," only called forth the congratulations of the doctor. There was much œdema and scanty urine. The child had, previous to the nephritis, impetigo capitis, and it was suggested by the friends that the subsequent evil came from "the driving in" of the eruption. We, in our folly, said, with some impatience, "Then you will see it again when the kidneys improve"; and we did see it again! I often wonder whether there is not more truth in this simple pathology than is thought.

A. U.—, æt. 20. Hæmatemesis, apparently due to gastric ulcer; yet in addition there was a big lump in right iliac fossa, and several clear attacks of appendicitis have since occurred. I have now met with several cases of the combination of hæmatemesis and appendicitis, and also of gastric ulcer cases (clinically ulcer) with considerable tenderness in the right iliac fossa.

J. A.—. Spasmodic torticollis of some years' duration. Was about to have his spinal accessory divided, but the suggestion of the necessity of first trying the effects of extracting some stumps was acted upon, and removed the necessity of further operation.

A. V.—, æt. 25. Had a partially detached placenta, and had had very severe hæmorrhage. The vagina was plugged, and several large books were firmly bound over hypogastrum. The bladder contained two pints of urine, and the uterus was distended with blood above it. The patient never recovered from the collapse. This tragedy shows us how rightly our teachers are in constantly reminding us of such a possibility.

I have often had to see other people's patients because they have spoken too much of the "crisis" in pneumonia. Crisis is a dangerous term to use in general practice, because patients think something very critical is to happen, much like they read of in novels, etc.; and, moreover, the crisis is apt not to occur, and what there is now is empyæma. The most loyal patient is apt to grumble at the disappointment of over-confident assurances of a happy ending after the crisis.

Acute otitis media is another disease which, I must say, others than I (now) seem to miss. No cause can be found for the pyrexia, headache, and vomiting, and the appearance of the discharge after "another opinion" brings no credit to anyone else.

I often ask myself how to avoid mistakes. There is no need to inculcate care in observation, care in hypothesis-making, and care in treatment. Care mixed with a healthy scepticism and a desire for truth does wonders. The necessity for experience is a trite saying. I recommend that men collect their mistakes and classify them. This seems a good prophylactic, because the more of anything we want to collect the more difficult the task becomes.

It is to the system we must turn if we would see the real cause of the unpopularity. What does a man look forward to who joins the R.A.M.C.? In three years he will be a captain and in twelve a major, that will come without any effort on his part; and if he has won the favour of his seniors, by diligence in sending in his weekly returns on the proper army forms, with the proper margin and through the proper official channels, if his diagnosis have been according to the regulations and not what he has learnt at his hospital, if his wards have been kept in order according to his regulations, the bedding properly folded up, the basins dressed by the left, if his diet sheets have been filled up each day—if all these things have been done he may look forward to the *summum bonum* of his profession, to the haven where he fain would be; he may be—oh the joy of it!—an administrative officer, no longer to be bothered with merely professional work, no longer to take any interest in his cases beyond seeing to the daily, weekly, monthly, yearly returns, but to sit all day in his office surrounded by clerks, and to administer a hospital, to be a P.M.O.

Just think of it! in fifteen to twenty years, just when a man who loves his profession looks forward to being a consulting physician or an operating surgeon, the R.A.M.C. man becomes a colonel and attends to clerical work which is done in any large London hospital in that mysterious place "the office."

To a man fresh from his hospital, with all the enthusiasm of youth before him, such a vista is enough to deter him from entering the R.A.M.C. A man who loves his work will not enter the R.A.M.C.; and a man who loves his leisure will not either, as the office work is laborious and the regulations exacting.

The system requires that if a certain rank is not reached by a certain age, the officer must retire on pension; thus it is usual to see men of from fifty to sixty retire with £1 a day. Now at fifty a man is too old to begin private practice, and too young to sit still for the rest of his days, until the time shall come when he reaches the limit of age allotted by the psalmist. The £1 a day may be sufficient to keep him a bachelor, but if perchance he be married, how can he properly educate his children on that?

This is the system in which a man must give up independence of thought and action, must merge his personality in that of the system, must attend carefully to the minutest details, and must study that most interesting of all human studies, the regulations. This is the system whose prize is to be an administrative officer and attend to merely clerical work and let me tell you the work is not nominal. When I first came out here and went to a general hospital I noticed a P.M.O. and his secretary, a major, who spent all day in their office, save for a weekly inspection by the P.M.O. when he came to see his hospital, not his hospital cases. I had no idea what the work meant until

fate ordained that I should have charge of an Indian field hospital. The two R.A.M.C. officers caught dysentery, and I was sent to Rooi Pyut to look after the working.

I found there five assistant surgeons, about 100 Indians, thirty Kaffirs, some European orderlies, and about ten patients. A field hospital (this was half of the 1st Cavalry Brigade Field Hospital), I should explain, is a small mobile hospital which moves with the column, and collects the cases from the field and sends them to the stationary hospitals. The office work even for a small hospital was considerable. I had to see to all the returns not only of the sick—that is but a fraction of the work; but also to the returns of the *personnel* and their rations, the animals and their forage. I had to wrestle with questions of discipline, with questions of the currency in paying the Indian and Kaffir natives, questions of equipment, questions of clothing, questions of sanitation, and many other questions; such, for instance: Two of my mules strayed away, and had to be found. Two generals and the P.M.O. Natal honoured me by making an inspection and speaking disrespectfully of the administration. I was not allowed to have the hospital long, and it was conducted on such new and enlightened principles, that I was relieved of my command and ordered to return to my original work, but it gave me an insight into the administration of a small hospital; and if the work be so great for a small mobile hospital equipped for fifty, how much greater must it be for a large general hospital equipped for upwards of 1000!

It is a system where no stimulus is given to individual enterprise, no man is encouraged to specialise on any given subject, promotion at first cometh not from the east nor from the west, but from seniority. Thus if a man with an ordinary pass degree gets his commission before an F.R.C.S. or M.D., he will be his senior, and may be able to overrule his diagnosis.

Let me digress to say a few words on the subject of the army diagnosis: it is a study in itself what diseases a man may and may not have: just a few examples by way of illustration. No man has tertiary syphilis even though he has well-defined nodes; I returned a man as phthisis, it had to be altered to tubercle of the lung; no man ever has a bubo, he has inflammation of connective tissue of the groin; not otitis media, but inflammation of the middle ear; not a gumboil, but inflammation of the dental periosteum; no mitral or aortic disease, but disordered valvular action; no tachycardia, but disordered action of the heart. A few words as to their statistics. The R.A.M.C. pride themselves on their returns. In the first place, according to the regulations, no man may have more than one disease at a time. In the diet sheets, together with the regiment, regimental number, actual service, service in the command, age, religion, etc. etc., there is

a small space for the diagnosis, and I foolishly gave a man a double diagnosis—rheumatism and pleurisy. I was immediately sent for by the divisional officer, and informed only one diagnosis at a time is allowed; it was immaterial which, but it was better that the one the man is more likely to die from should be returned.

In this present war the inoculation for enteric has been carried on on what might be termed the manufacturing scales, and the full returns are awaited with considerable interest; but as the War Office allows a diagnosis of s.c. fever to be made, it vitiates all the statistics. Whether s.c. fever means simple or slow continuous fever I have not been able to understand. But the undoubted fact remains that many cases of fever are returned as s.c. fever that are really mild enteric. A man is not allowed to die of s.c. fever; if, unfortunately, he should die with that diagnosis it is changed to enteric. No attempt is made to distinguish between s.c. fever and enteric; it is merely the caprice of the medical officer which is returned. Medical officers in charge of stations will not return cases of enteric and dysentery unless actually obliged to do so, as with stationary troops each case so returned reflects on the sanitary condition of the camp, and therefore on the medical officer as the responsible sanitary officer; and if the sanitation is not satisfactory the medical officer will not be viewed with satisfaction by those in authority, and that means he will not be mentioned in despatches and receive the coveted C.B.; there is, therefore, a great temptation to return enteric and dysentery as s.c. fever and diarrhoea.

A case recently came into hospital in which the diagnosis of subacute rheumatism had been made. On examination it was found that the prepatellar bursa was suppurating. It was opened and drained; yet it was not shown as an error in diagnosis, loyalty among colleagues being considered above accuracy in statistics.

Debility and anæmia are among the official diagnoses, and this is hardly fair to the patients, as when near the base tram-loads of sick came down diagnosed as debility with no record, and only the patients' statement that they had had enteric. Now had the diagnosis enteric been left, the probability is that the patient would have been invalidated to England; but with debility, a convalescent camp, and duty on the lines of communication. This, I maintain, is hardly fair on the patients themselves, apart from statistical value. Anæmia in man I leave for pathologists and gynaecologists to comment on!

To reform the R.A.M.C. it is not sufficient to increase the pay, though that may induce many more to join. It is maintained that it is necessary to have military discipline in the military hospitals, but why necessary? In London hospitals, where the most deprived of mankind is collected, there is no difficulty in maintaining discipline. Reform of the R.A.M.C., to be efficient, is not in listening

to their so-called grievances of military rank and of uniform, but in reforming the system itself.

Machadodorp, Transvaal,  
April 24th, 1901.

### To the Colleges.



E are M.R.C.S. England and eke L.R.C.P.,  
But we're whining and we're pining  
To adorn our brass plates shining  
With the elegant M.D.,  
The coveted degree.

For we feel that there are dozens  
Of provincial doctor cousins,  
Who really ought to be  
No better off than we.

Not to mention that at present  
Much more work than we find pleasant  
Is a stern and grim essential  
For the treatment deferential  
That is due to the M.D.  
But, O ye Powers that be,  
We'd dearly love to see  
Ourselves with this degree.

J. K. R. T.

### A Case of Diabetic Coma in a Girl of Eleven.

By J. HOWARD MEACHER, M.R.C.S., L.R.C.P.



I N April of this year a girl, æt. 11, walked with her mother a distance of a mile to my house to see me. The mother, who is a farm labourer's wife, told me that she had noticed that the child had seemed poorly and fretful for a week or two past, although she had been able to attend at school until a week previously. She had been losing flesh, and complained of pain in the stomach and headache. Three days before coming to see me she was playing about with other children, but since then had become very weak and listless, and the mother thought it time to consult a medical man.

Her opinion was that the child had worms; at any rate she had seen one a few days previously that she had passed.

I found the girl very emaciated, with features drawn and eyes sunken. The temperature was subnormal, and pulse feeble and rapid, but this I ascribed to nervousness. The lips, tongue, and interior of the mouth were very dry and parched, and she complained of pain in the mouth, but nowhere else. I noticed at the time a peculiar sweet odour about the breath. Examination of the chest and abdomen revealed nothing abnormal. I thought she had worms, and prescribed a castor oil and calomel powder to be taken at night, and a saline purge first thing in the morning, and directed the mother to let me know if she thought it necessary for me to call and see her the next day.

The following afternoon I was sent for hurriedly, and found the patient in a state of complete collapse, in fact almost unconscious. This had commenced about 10 a.m., but was rapidly getting worse. She lay on the bed with eyes half open, taking no notice of anyone. Although it was possible to arouse her somewhat by speaking to her, she did not appear to comprehend what was said, and immediately lapsed back into her old state. The pulse was very quick and feeble, the surface of the body cold, and the extremities livid. The sweet smell of the breath was very marked, permeating the atmosphere for some distance around, and reminding one of the smell of chloroform. The breathing was slow, deep, and sighing in character, and on auscultation numerous moist râles were heard over both lungs, and also rhonchus and sibilus. The patient had passed no urine for about twelve hours, and there had been obstinate constipation for two or three days past. The smell of the breath aroused my suspicions as to the true nature of the case, and on questioning the mother she admitted that the child had appeared very thirsty for a week or two past, frequently asking for water to drink, and that she had complained that she was obliged to get out of bed in the night three or four times to micturate. I was fortunately able to obtain some of the urine, and on examination found it loaded with sugar.

It was clearly a case of diabetic coma, and terminated fatally at 3 o'clock the following morning, exactly thirty-six hours from the time the child had walked a mile to my surgery.

The case is interesting on account of the comparatively rare occurrence of diabetic coma in so young a subject, and because of the rapidity with which the disease proved fatal—three weeks at the outside from beginning to end.

### A Case of Röntgen Ray Ulceration.

By F. A. ROSE, B.A., M.R.C.S., L.R.C.P.



THE following case is of interest as showing the extensive damage to the skin which may follow prolonged exposure to the Röntgen rays.

R. D., æt. 50. Weight 15 stone 10 lbs. Horse-breaker.

On August 2nd, 1900, his left hip was dislocated. He was taken to Newark Hospital.

21st.—His left hip was exposed to Röntgen rays for thirty-five minutes at a distance of six inches.

22nd.—An area of redness the size of a dinner plate appeared on the left side of the front wall of the abdomen, above Poupart's ligament and on the inner side of the thigh. This was treated with methylated spirit and powder and disappeared.

September 14th.—The red area reappeared on the abdomen accompanied by pricking pain.

23rd.—Patient left the hospital.

26th.—Pimples appeared on the red area.

30th.—The patient had severe burning pain, and bullæ the size of a hen's egg appeared on the red area. The skin then came off the entire area in sloughs leaving an ulcer which measured fourteen inches across. Healing of the ulcer was extremely slow and was accompanied by increasing pain, which was felt not only in the ulcer but round the left loin.

By February 26th, 1901, the size of the ulcer was reduced to three inches by one and a half. It was then scraped with a Volkmann's spoon, with the result that it increased in size.

After this date he came to London, and on March 20th, 1901, he was admitted to Sitwell. The ulcer then measured four inches by two and three quarters. The border consisted of a band of pale yellow slough half an inch broad. The base was depressed, red, and covered by sparse granulations.

After three weeks' treatment with fomentations the ulcer was shallower but no smaller.

He complained much of pain, and seldom slept more than four hours during the night.

Points of interest about the case are—

1. That although the skin became red soon after exposure to the Röntgen rays, yet the redness disappeared, and no ulcer was formed until six weeks later, when the patient had left hospital, and presumably less care was bestowed on the injured skin.

This and its extremely slow healing suggest comparison with the trophic ulcers of locomotor ataxy and the corneal ulcers met with in fifth nerve paralysis. But the pain suffered is a distinguishing feature.

2. That although the rays have passed through the patient's body, as shown by their influencing the sensitive plate, there is no evidence that any of the tissues so penetrated are damaged, except the skin at the point where the rays enter.

This note is published by the kind permission of Mr. Butlin, under whose care the patient is at present.

### Case of Placenta Prævia.

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



LEANOR K., aged 41. Previous labours, nine; the last three years ago, when there were twins. No history of pelvic inflammation.

On 30th April, 1901, assistance was sent for, at 2 a.m., on account of bleeding *per vaginam*. Labour pains had not commenced. Bleeding began at 1 a.m., and several elongated clots were passed. A week ago there had been similar bleeding, but as it subsided after rest no assistance was sought on that occasion. Nothing else abnormal had been noticed whilst "carrying."

5 a.m. *general condition*.—The patient was a stout, sallow, and somewhat anæmic woman, but by no means exhausted. Temperature 99 $\frac{1}{2}$ ; pulse 100.

*Per abdomen*.—Fœtal movements could be felt. Fœtal heart, 150. L.O.A. position. Labour pains had commenced.

*Per vaginam*.—A clot of blood was felt coming from the uterus. The os admitted three fingers. The placenta was lying directly over the internal os. The membranes were intact, and could be felt with the tip of the finger in the right posterior quarter about two inches from the internal os. In separating the placenta from the wall of the uterus, by sweeping the finger round as high as one can reach, it was found that the greater part of the placenta was attached to the anterior wall of the uterus. The vertex was felt through the placenta.

5.45 a.m.—Bi-polar version was attempted under chloroform. The head was pushed up and the shoulder reached, but it was not possible to complete version by this method, though the fingers were passed through the placenta. As the patient was losing blood considerably, the os was dilated with the fingers, and internal podalic version was performed. To do this it was necessary to pass the hand right through the placenta.

6.5 a.m.—No more chloroform was given. The expulsion of the child was left to nature, and was not hurried in any way.

7.30 a.m.—The child was born dead. It was a male, and weighed 8 lbs. The placenta was born in two pieces. The first measured 4 by 4½ inches, and was expelled at the same time as the breech. The second portion was expelled with the head, and measured 2½ by 8 inches. The whole placenta measured 11½ by 8 inches, and weighed 14 lbs. It contained no fibrous masses.

7.32 a.m.—Ergotin was injected into the buttock.

7.35 a.m.—An intra-uterine douche of perchloride of mercury, 1 in 8000, was given at a temperature of 118° F.

8.15 a.m.—Saline solution was given *per rectum*, one pint.

9.40 a.m.—General condition very good. Pulse between 80 and 90. There was no bleeding after the leg was brought down. The pains throughout were strong and frequent. The puerperium was uneventful.

*Comment*.—The case was a typical one of placenta prævia. It was the central variety. The points chiefly to note are the ante-partum hæmorrhage, which raised the suspicion of placenta prævia, and the feeling of the placenta over the os which enabled one to diagnose it. As regards prognosis, four conditions were in favour of giving a good one for the mother, viz.:

1. Absence of exhaustion from repeated hæmorrhage before onset of labour.
2. Absence of any malpresentation.
3. Presence of strong and frequent pains.
4. The easy dilatation of the cervix.

On the other hand, hæmorrhage was likely to prove more dangerous in labour at full term than in labour earlier in pregnancy. With respect to treatment there is nothing original. The dictum of Herman was borne in mind, to wit: "Early turning, slow extraction, antiseptics." And to this might be added "ergot." No attempt was made to save the life of the child, for it is well known that the safety of the mother is antagonistic to that of the child. Treatment to save the child imperils the mother, and what is best for the mother endangers the child.

With respect to the placenta, its weight, size, and thickness should be noted as characteristic. The weight was about 20 ounces, the same as that of a normal placenta. But the area was considerable, one diameter measuring nearly a foot, and nowhere was its thickness much more than half an inch. It was, in fact, a large, flat, thin placenta.

I take this opportunity of expressing my indebtedness to Dr. Griffith for permission to publish this note.

### Notes.

THE King, who has been President of this Hospital for thirty-four years, has consented to become Patron of the Hospital on ceasing to be its President. A fund has been started to place a bust or some other suitable memorial of the office which he has honoured us by holding, on the staircase of the Great Hall.

OWING to the national mourning and the close connection of His Majesty with the Hospital, it was decided not to hold this year the Annual View Dinner.

DR. WEST has been elected Joint Lecturer on Medicine.

MR. BOWLEY has been appointed Joint Lecturer on Surgery.

SIR DYCE DUCKWORTH has resigned his appointment as representative of the College of Physicians on the General Medical Council. Dr. Norman Moore has been elected to the vacancy.

DR. A. T. DAVIES has been selected Orator to the Hunterian Society for 1902, and has also been elected President of the Æsculapian Society for the ensuing session.

DR. CALVERT has resigned the post of Medical Registrar and Demonstrator of Morbid Anatomy.

THE Brackenbury Medical Scholarship has been awarded to F. C. Shruball.

THE Kirkes Gold Medal and Scholarship has been awarded to A. E. Thomas.

THE Senior Scholarship has been won by A. Hamilton.

A. D. PUGH, M.R.C.S., L.R.C.P., has been the recipient of a handsome testimonial on resigning the appointment of House Surgeon to the Huntingdon County Hospital.

The testimonial took the form of a travelling clock, subscribed for by 150 people in the two boroughs of Huntingdon and Godmanchester. It bears the following inscription:

"Presented to A. D. Pugh, M.R.C.S., L.R.C.P., in grateful recognition of his kind attention and skill, by many patients in Godmanchester and Huntingdon, April, 1901."

We see the name of T. Fowler appearing in the papers regularly in the Gloucestershire County Eleven: he has so far made some very sound scores.

THE following notice which recently appeared in the *City Press*, will be interesting to Bart's men.

"THE CITY'S MEDICAL OFFICER.

"Dr. William Collingridge, M.A., M.D., LL.M., the newly-appointed Medical Officer of Health of the City of London, is the eldest son of Mr. W. H. Collingridge of Enfield and the *City Press*, Aldersgate Street. Dr. Collingridge was born in Islington in 1854, and educated at Clewer House School, Windsor, after leaving which he was for a short time engaged in his father's business. In 1872 he entered as a student at St. Bartholomew's Hospital, and in 1877 qualified as a medical practitioner. In 1875 he entered Christ's College, Cambridge, at which University he took the degrees of M.A., M.B., D.P.H., and M.D., and subsequently that of LL.M. During the Turco-Serbian war, in 1876, Dr. Collingridge, then a student, went out to Belgrade as a volunteer surgeon, and was the first English surgeon to arrive. He was warmly received by the Minister of War and the Archbishop of Belgrade. He immediately received a commission as surgeon, and left for the army before Novi-Bazar. He there organised their hospitals. Dr. Collingridge left London and entered upon this duty without pay, appointment, or companion. At the termination of the struggle Dr. Collingridge was decorated by King Milan with the order of the Takova. The post of Medical Officer of the Port of London being vacant by the death of Dr. Harry Leach, the Corporation appointed Dr. Collingridge as his successor. From his college days Dr. Collingridge has been an ardent volunteer, having served in the University Corps and the Field Battery of the Honourable Artillery Company, and more recently as adjutant of the Woolwich division of the Volunteer Medical Staff Corps. In 1892 he was appointed as Surgeon-Major to the command of an experimental company of the new Militia Medical Staff Corps, which was stationed at Aldershot for its first year's training. This company proving successful, the corps was enlarged to eight companies. In 1898 Dr. Collingridge was appointed Surgeon-Lieut.-Colonel Commanding, a post from which he retired in 1900. Dr. Collingridge has often lectured and examined for, and takes an active part in the work of the St. John Ambulance Association. He is a Knight of Grace of the Order of St. John, and was the first President and is now the Vice-President of the Life-Saving Society. Dr. Collingridge was appointed the Milroy Lecturer to the Royal College of Physicians in 1897. Examiner in State Medicine to the University of Cambridge in 1898, and the official delegate of the University of Cambridge to the International Congress of Hygiene held in Paris last year. He is the author of 'Occurrence and Significance of Hemorrhage in Typhoid Fever,' 'Scurvy in the Mercantile Marine,' 'Water and Filtration,' 'Quarantine in England,' 'Duties of Sanitary Inspectors,' etc."

Congratulations to the Boat Club on their successes this year in the Inter-Hospital Races. We believe this is only the second year of the Club's revival, and with such materials as we possess, the possibility of the Hospital being represented at Henley in the near future does not seem quite so remote as the *Boat Club News* of last month gave us to understand.

In this issue appears an article on the "Causes of the Unpopularity of the R.A.M.C." by a Bart.'s man in South Africa. The subject is trite, the facts he quotes may not be new; but our excuse for re-opening the old question is that if any improvement is to be made in the system we must go on hammering at the same nail until we impress on the minds of the War Office authorities the fact that members of the Medical Profession are not without pride in their calling, and that if doctors elect to serve with the army, they do not intend to let War Office regulations replace the traditions of our art, nor to cease to be men of science because they are given empty titles which in name imply combatant rank.

WHERE are those tastefully arranged baskets of flowers that used to be hung every View Day from the corners of the shelters in the Square. Without them all was dark and cheerless; even the methylene blue in the fountain could not restore to the Square its former gaiety.

Is it true that a rival has stolen these treasures from us?

So we are to have a new qualification, the "M.D. England," or there are some in our midst who clamour for it, which perhaps is not the same thing. Our worthy colleagues who are agitating for the substitution of the above high-sounding degree, in place of the well-known and world-famous "M.R.C.S., L.R.C.P.," seem to overlook the obvious retort, that their efforts "to raise the value of the qualification" (we quote from their circular) scarcely imply so great a faith in the qualification, as their earlier remarks in the same circular would lead us to suppose they possess.

To a less aspiring soul, that prizes the double qualification, not only for its academic worth but also for its historic associations, it might occur to add that a practical way "to raise the value of the qualification," would be for our aggrieved friends to resign their diplomas.

The idea that the practice of medicine is nearly allied to the Black Art seems to be by no means defunct even in London, if one may judge by the following experience of a busy practitioner. One morning a man called at the doctor's surgery, wanting him to go and see his wife; but being in a hurry the man could not wait for a personal interview, so wrote on a scrap of paper his idea of his wife's trouble: "This case is an inside complaint there is a substance that my wife cannot pass her water which causes the greatest agony you know by this what the case is, if probably you may require an injector to draw off water." Beside this "case for diagnosis," the conundrums of a mid-wifery examination paper are self-evident propositions.

A DAILY paper recently appeared with a paragraph beginning "Ping Pong has found its way into the life of the ministering angels at St. Bartholomew's Hospital." A jaded

house surgeon overhearing this much, interrupted petulantly, "Hullo! what's that about the junior staff?"

THE Past v. Present Cricket Match will take place, with the usual attractions, at Winchmore Hill, on Wednesday, June 12th. We do not mind promising that the weather will be fine, but will accept no responsibility for it.

THE Annual Dinner of the Eighth Decennial Contemporary Club will be held at the Café Royal, on Wednesday, June 26th, at 7.30 p.m.

The Mid-Sessional Address of the Abernethian Society will be delivered in the Anatomical Theatre by Dr. Ormerod, on Thursday, June 27th, at 8 p.m.

THE Summer Concert will take place this year on Monday, June 24th. We understand that the usual arrangements for refreshments in the Square, which have previously proved so successful, will again be carried out.

AN advanced class in Operative Surgery will commence on June 13th at 4.15 p.m. This will be the last class held before the examinations for the Services in August.

Amalgamated Clubs.

CRICKET CLUB.

ST. BART.'S v. MR. H. E. G. BOYLE'S XI.

The Hospital opened their season at Winchmore Hill on Saturday May 11th, with a match against an XI get together by Mr. H. E. G. Boyle, and after an exciting finish claimed a victory by five runs. The XI, batting first on a soft wicket, were dismissed for 129. We on taking the field succeeded in getting rid of the opponents for five less.

SCORES.	
MR. H. E. G. BOYLE'S XI.	HOSPITAL.
H. W. Pank, c Nicholas, b Nealeor	C. Elliott, b Boyle
L. V. Thurston, c Orton, b Page	L. Orton, c and b Pank
H. E. Scoones, b Howell	W. S. Nealeor, b Turner
J. C. Willett, b Burroughes	H. N. Burroughes, b Boyle
H. E. G. Boyle, b Nealeor	C. A. Anderson, c Pank, b Turner
C. H. Turner, c Wilson, b Burroughes	C. M. H. Howell, b Turner
L. B. Rawling, c Howell, b Anderson	C. F. Nicholas, c Bostock, b Turner
T. M. Body, b Nealeor	G. H. Adam, c and b Pank
A. H. Bostock, c Elliott, b Anderson	H. T. Wilson, c Rawling, b Pank
E. F. Rose, c Anderson, b Nealeor	W. C. Honiball, b Pank
J. Corbin, not out	G. F. Page, not out
Extras	
Total	Total

BOWLING ANALYSIS.

Overs.	Maidens.	Runs.	Wickets.
Page	11	3	24
Elliott	7	1	22
Howell	5	1	14
Nealeor	8	0	32
Burroughes	6	1	24
Anderson	3	1	6

2nd Match.—ST. BART.'S v. HENLEY.

Played at Henley on Saturday 18th, resulted in a somewhat easy victory for the Hospital by 88 runs. W. S. Nealeor and C. A. Anderson were top scorers for the Hospital, with 60 and 55 respectively.

HOSPITAL.		HENLEY.	
C. F. Nicholas, b M. Molloy	2	B. Molloy, run out	27
W. S. Nealeor, c Tuckett, b M. Molloy	60	P. D. Tuckett, b Boyle	55
C. A. Anderson, b M. Molloy	55	A. Finch, c Adam, b Phillips	33
C. Elliott, l b w, b M. Molloy	9	M. Molloy, c Page, b Anderson	20
H. E. G. Boyle, c B. Molloy, b M. Molloy	28	J. F. Cooper, c and b Adam	27
H. T. Wilson, b M. Molloy	2	R. W. Brakespear, b Boyle	23
T. M. Body, b M. Molloy	36	L. L. Bailey, c Adam, b Boyle	7
G. H. Adam, c Fryer, b M. Molloy	11	P. F. Tuckett, c Elliott, b Adam	8
L. L. Phillips, c and b M. Molloy	19	Rev. J. H. Brooke, b Boyle	0
G. F. Page, c H. Molloy, b M. Molloy	5	E. J. Fryer, not out	5
R. N. Miller, not out	0	Packer, c Wilson, b Boyle	4
Extras	2		
Total	253	Extras	6
		Total	165

BOWLING ANALYSIS.

Overs.	Maidens.	Runs.	Wickets.
Boyle	14	1	53
Nealeor	1	0	10
Elliott	7	1	23
Adam	8	0	34
Phillips	0	0	17
Anderson	5	0	22

3rd Match.—ST. BART.'S v. ENFIELD.

Played at Winchmore Hill on Wednesday 20th, resulted in an easy win for the Hospital by 4 wickets and 118 runs, this making the third successive victory out of three matches played. This match was chiefly characterised by the fine innings by H. N. Burroughes and W. S. Nealeor, who scored 113 and 105 respectively; this was only Burroughes's second match for the Hospital, so we shall expect great things from him in the future; Nealeor, on the other hand, has played many fine innings for us, but has never before succeeded in scoring over 100 runs.

ENFIELD.		HOSPITAL.	
J. C. Bevington, c Page, b Howell	34	H. N. Burroughes, c Bailey, b Staikley	113
L. G. Couves, c Anderson, b Honiball	21	C. A. Anderson, run out	7
G. Pratt, b Honiball	9	W. Honiball, c Burns, b Staikley	10
M. Jendwine, c Nicholas, b Page	41	W. S. Nealeor, c Bailey, b Burns	105
Rev. J. T. Barns, c Orton, b Honiball	8	C. M. H. Howell, b Staikley	4
R. Goring Thomas, run out	8	C. F. Nicholas, l b w, b Staikley	7
H. L. Thoms, c Phillips, b Page	16	L. Orton, not out	0
S. Staikley, b Howell	7	G. H. Adam	0
J. Gomm, c Burroughes, b Adam	11	C. Elliott	0
L. Fevey, b Page	9	L. L. Phillips	0
W. K. Dailey, not out	3	G. Page	0
Extras	7		
Total	168	Extras	37
		Total	286

BOWLING ANALYSIS.

Overs.	Maidens.	Runs.	Wickets.
Adam	14	2	41
Page	8	0	35
Howell	14	4	38
Honiball	12	2	25
Anderson	4	2	10

SWIMMING CLUB.

United Hospitals v. Oxford University.—This match was played at Oxford on May 11th. The Hospitals took down a very strong team and defeated the Varsity by five goals to one. The Hospitals defended the shallow end for the first half, and after some fast play Hughes was enabled to score the first goal from a good pass by Nesfield. With this encouragement the Hospitals attacked strongly, and from a pass from Newby-Smith, Thorne registered the second goal. Some good play ensued, in which Dean for the Varsity was most conspicuous, several times preventing Wallace from scoring. There was a good deal of play at both ends of the bath, and neither side were able to claim any advantage until just before half-time. Thorne, after a very good bit of play, scored a third goal. In the second half there was some very even play for a few minutes, until Lindsay, from a good pass by Dean, was able to score with a very hot shot, the only goal for Oxford. The Hospitals continued to press strongly, and Thorne scored two more goals within a few minutes of each other. Just before time Lindsay tried another shot at goal, but the ball fell just too short, and time being called, the Hospitals won as above stated. Before the Polo match there was a 60-yards team race, which was won by the United Hospitals by two yards. The teams were as follows:

United Hospitals.—C. Dix (goal); V. B. Nesfield (capt.) (St. Mary's); R. Newby-Smith (London) (backs); A. H. Bloxome (St. Bart.'s) (half back); W. H. C. Thorne (St. Bart.'s), C. G. M. Hughes (Westminster), and J. Wallace (St. Thomas's) (forwards).  
Oxford University.—A. O. V. Houseman (Lincoln) (goal); H. R. Dean (New), W. Hill (Trinity) (backs); H. C. Verney (Trinity) (half back); H. G. D. Turnbull (University), C. M. Lloyd (St. John's) (capt.), and H. A. F. Lindsay (Worcester) (forwards).

St. Bartholomew's Hospital S.C. v. Ealing S.C.—This match was played on May 17th at Ealing, and resulted in a defeat of the Hospital by three goals to nil. In the first half the Hospital defended the deep end, and for several minutes there was no scoring at all. The Hospital were the first to attack, and Stone had a shot at goal, but the ball went just outside the post. Ealing then transferred the ball to the other end, and after some good play, particularly by the Hospital backs, Wilkinson scored the first goal for Ealing. This put Bart.'s on their mettle, and some fine play resulted, mostly in the centre of the bath. Thorne tried a shot at goal, but the ball went wide, and half-time was called with Ealing leading by one goal to nil. During the second half the Ealing forwards took the ball right up to the Hospital goal, and after some fast play Wilkinson scored a second goal. In the next few minutes play took place more in the centre of the bath, Stone doing some very useful work, more than once preventing Nesfield from passing. The Hospital forwards had one or two shots at goal, but failed to score, and immediately afterwards Wilkinson tried another shot, but was not successful; however, a minute or two later he was able to score the third goal for Ealing with a very hard shot, time being called soon afterwards. The teams were:

St. Bart.'s.—C. Dix (goal); J. G. Watkins, V. C. Upton (backs); A. H. Bloxome (capt.) (half back); W. H. G. Thorne, D. M. Stone and R. C. McDonagh (forwards).  
Ealing.—C. Metcham (goal); V. B. Nesfield (capt.), W. F. Bryant (backs); J. Walker (half back); L. Thornhill, W. Pitt, and B. Wilkinson (forwards).

United Hospitals v. Surrey County.—This match was played at Southwark Baths on Tuesday, May 21st, and resulted in a win for Surrey by the large majority of 7 goals to 2. The Hospitals were not represented by a very strong team, as two of their best forwards, J. Wallace (St. Thomas's) and W. H. C. Thorne (St. Bart.'s) were both unable to play. In the first half Surrey defended the deep end, and almost immediately after the start the Hospitals' forwards pressed strongly with the result that Levers with a good shot scored the first goal. On restarting Peter Kemp quickly got possession, and after some passing between the Surrey forwards, Saunders scored a goal, and soon after added another. Some good play followed, in which Nesfield and Newby-Smith were prominent, and Bloxome ably seconded them. Just before half time Saunders obtained another goal, and on crossing over Surrey led by 3 goals to 1. In the second half Surrey had the game very much in their own hands, and by means of Kemp, Newton, and Saunders added four more goals before time was called. The second goal for the Hospitals was obtained by Hughes by a long shot towards the end of the second half.

United Hospitals.—C. Dix (St. Bart.'s) (goal); V. B. Nesfield (capt.) (St. Mary's), and R. Newby-Smith (London) (backs); A. H.

Bloxsome (St. Bart.'s) (half-back); O. Jevers (St. Mary's), C. M. G. Hughoe (Westminster), and D. M. Stone (St. Bart.'s) (forwards).  
*St. Bart.'s v. South London Harriers' S.C.*—Played at St. George's Baths on Thursday, May 23rd, and resulted in a win for the Hospital by two goals to one. The South London Harriers turned up with only five men, and as the Hospital giving them a substitute and only playing six men made a very even game. Bart.'s played up well, and from a good pass Bloxsome swam right up the bath and was enabled to score the first goal. There was a good deal of give-and-take play at both ends of the bath, and just before half-time Stone scored the second goal with a very good shot. Soon after the restart Windsor obtained a goal, and the game became very equal, neither side being able to claim any advantage, and time was called, leaving the Hospital winners as stated. Teams:  
*St. Bart.'s*.—C. Dix (goal); V. C. Upton and G. T. Verrey (backs); A. H. Bloxsome (capt.) (half-back); D. M. Stone, and J. G. Watkins (forwards).  
*South London H.*.—A. Owen-Turner (goal); P. Tittley and A. W. Creasy (backs); F. Windsor (half-back); J. A. Elston and A. Slater (forwards).

## BOAT CLUB.

The Annual Inter-Hospital Boat Races were rowed off on May 21st, and Bart.'s was successful in both events. Unfortunately our rather formidable combinations scared away most of our rivals, and only the London Hospital's 1st boat came to the post.

The race was followed by the steam launch 'May Queen,' which carried a small but select number of spectators, the majority of whom were Bart.'s men and their lady friends.

## Our crews were:

<i>1st Boat</i>		<i>2nd Boat</i>	
Bow—J. G. Slade.		Bow—H. E. Graham.	
2—H. O. Gould.		2—B. Hudson.	
3—R. B. Etherington Smith.		3—R. G. Noke.	
Stroke—J. E. Payne.		Stroke—N. A. W. Conolly.	
Cox—F. Whittaker.		Cox—R. G. Williams.	

Bart.'s won the toss and took the Middlesex station. At the word "go," Bart.'s were the first to get hold of the water and immediately began to show in front of the London, and were soon clear. The London were then content to drop behind, and the rest of the race was little better than a procession. Bart.'s continued to gain, and finished at a paddle five lengths in front.

The second boat had previously rowed over in their event. It was unfortunate that they had no opponents, as they had taken a lot of trouble and had turned out a good crew and fast.

It was at one time hoped that arrangements might be made for them to row with the first four, but this could not be managed.

This is, it seems, the first time that Bart.'s has won either of the Rowing Challenge Cups. May they now continue to adorn our library for many years.

## View Day.



THE annual View Day fell on the 8th of May, being held as usual on the second Wednesday of the month. The ancient View Day ceremonies—which bring the fact home to us every year that we have the honour to belong to a very old institution—admit of no modifications, but to which they are set in an ever-varying one. Fancy some of the old worthies of a hundred years ago joining in this year's procession! Their amazement would have been great, and we can hardly flatter ourselves that they would have bestowed unequalled approval on the changed aspect of their old hospital wards.

Modern ideas of flower decoration would have struck them as very curious; trails of smilax and asparagus-fern, which do so much to beautify the wards, would have been denounced by them as untidy, and apple- and pear-blossom would have shocked them as being sinfully wasteful. If they ever used flowers at all for decorative purposes they probably indulged in those delightful pyramidal posies which our young neighbours, the Christ's Hospital boys, carry round at their Lenten suppers—now, alas! extinct as public functions.

This year, we think, some of the wards showed distinct originality, and all of them displayed exceedingly good taste in restriction of colours and selection of flowers. We are approximating more and more the Japanese idea of displaying single flowers to show their beauty of form to full perfection instead of massing them in bunches, whose form is sacrificed. Some flowers, of course, must be massed, or the effect would be insignificant; but the roses and lilies and irises in many of the wards were arranged with effective restraint and artistic grouping.

We have never seen more roses on View Day than were found in the wards this year. Mary, in particular, had no other flower, and was quite prodigal in its profusion. It was not only a bower of roses, but the home of charming little girls, who presented rival claims on the admiration of the visitors. It is always a matter of astonishment where the pretty children who grace the wards both at Christmas and on View Day are mysteriously procured, but there they always are! In several of the wards this year there were beautiful children, looking much more suggestive of heaven than of the slums from which they probably came.

Paget had charming roses, also Faith, Ophthalmic, and Casualty. In Casualty the roses mingled their beauty with tall white lilies, to the advantage of both. Laurence and Rahere had pink geraniums, the latter with bowls of forget-me-nots and roses. Rahere also had its mantelpiece most picturesquely decorated with trailing ivy-leaved geraniums, the effect of which was exceedingly pretty. In Elizabeth the hydrangeas were much admired, and in Kenton the pretty ixias. In Martha delicate white lilacs called for special notice, and in Mark and Lucas choice white lilies.

Some of the wards pressed the flowers of the fields and woodlands into their service. Perhaps the most successful in this line was Coborn, which had masses of gorse and daffodils. Sitwell had a profusion of bluebells, and Charity confined itself entirely to cowslips. Abernethy had a beautiful basket of yellow and white flowers, which showed a skilled hand in its arrangement, and, on the whole, yellow and white were the prevailing colours throughout the Hospital. Darker was almost entirely yellow, and very pretty it looked.

In every ward there was, in fact, something individual to admire, and it is difficult to limit the approving remarks each separate ward evoked.

The usual hospitality was exercised by the nursing staff in the matter of View Day teas, which were exceedingly well attended in spite of the virulence of the weather at intervals. The traditional fine View Day weather did not remain true to its reputation, for it behaved capriciously and unkindly in the early part of the day; but, to its credit be it spoken, it regained its serenity towards evening, and the day closed with a clear sunset.

## The Rahere Lodge, No. 2546.



AN ordinary meeting of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street, W., on Tuesday, May 14th, W. Bro. Walter Gripper, M.B., W.M., being in the chair. Bros. Ware and Beadles were raised to the Third Degree, while Mr. David Boyd Keown, M.R.C.S. Eng., L.R.C.P. Lond., was initiated into Freemasonry. Grants of Ten Guineas each were voted for the Boys' School and the Institution for Girls. W. Bro. Phineas S. Abraham, M.D., was elected W.M. for the ensuing year, while W. Bro. Clement Godson, M.D., was re-elected Treasurer. Subsequently a number of the Brethren dined together.

As an example of the "sweet reasonableness" of some Hospital Patients this seems to rank high.

MOTHER (on finding that an overworked House Surgeon is disposed to examine her sick child)—"Now, Doctor! I ain't going to 'ave my child examined; all you've got to do is to take 'er in!"—*exeunt ambo.*

## Calendar.

June, 1901.

Sat.,	June 1.	—Cricket v. M.C.C., at Winchmore. Swimming Club v. Cambridge University, at Cambridge.
Tues.,	" 4.	—Sir Lauder Brunton and Mr. Walsham's duty.
Wed.,	" 5.	—Mr. Butlin's Clinical Lecture at 2.45 p.m.
Fri.,	" 7.	—Sir William Church and Mr. Willett's duty. Sir Lauder Brunton's Clinical Lecture at 1 p.m.
Sat.,	" 8.	—Cricket v. Waldegrave Park, at Winchmore. Swimming Club v. Oxford University, at Oxford.
Mon.,	" 10.	—Swimming Club v. Richmond, at Richmond.
Tues.,	" 11.	—Dr. Gee and Mr. Langton's duty.
Wed.,	" 12.	—Mr. Marsh's Clinical Lecture at 2.45 p.m. Cricket, PAST v. PRESENT, at Winchmore. Swimming Club v. South London Harriers, at Clapham.
Thurs.,	" 13.	—Sir G. Burrow's Prize; Skynner Prize.
Fri.,	" 14.	—Sir Dyce Duckworth and Mr. Marsh's duty. Sir William Church's Clinical Lecture at 1 p.m.
Sat.,	" 15.	—Cricket v. Addlestone, at Addlestone.
Tues.,	" 18.	—Dr. Hensley and Mr. Butlin's duty.
Wed.,	" 19.	—Mr. Marsh's Clinical Lecture at 2.45 p.m. Swimming Club v. Richmond, at St. George's Baths.
Fri.,	" 21.	—Sir Lauder Brunton and Mr. Walsham's duty. Dr. Gee's Clinical Lecture at 1 p.m. Swimming Club v. Ealing, at Ealing.
Sat.,	" 22.	—Cricket v. Barnet, at Winchmore.
Tues.,	" 25.	—Sir William Church and Mr. Willett's duty.
Wed.,	" 26.	—Mr. Marsh's Clinical Lecture at 2.45 p.m. Cricket v. Hornsey, at Hornsey. Swimming Club v. Oxford University, at St. George's Baths.
Thurs.,	" 27.	—Abernethian Society Mid-Sessional Address at 8 p.m., by Dr. Ormerod. Examination for London Intermediate M.B. begins.
Fri.,	" 28.	—Dr. Gee and Mr. Langton's duty. Sir Dyce Duckworth's Clinical Lecture at 1 p.m.
Sat.,	" 29.	—Cricket v. Dunstable Grammar School, at Dunstable.

## Reviews.

APPENDICITIS: ITS PATHOLOGY AND SURGERY. By CHARLES BARRETT LOCKWOOD, F.R.C.S., Assistant Surgeon and Lecturer on Descriptive and Surgical Anatomy in St. Bartholomew's Hospital, etc.

This book may be divided into three parts, dealing respectively with—(1) the anatomy of the appendix; (2) the pathology and morbid histology; (3) the symptoms and treatment of appendicitis. The anatomy of the normal organ is fully described, and several important points are brought out which enable us to explain certain results of appendicitis. For instance, there are gaps—hiatus muscularis—in the muscular coats which transmit the blood-vessels, nerves, and lymphatics from the meso-appendix to the submucous and mucous coats; the connective tissue of these coats is continuous with that of the subperitoneal tissue. These gaps are found at the caecal end of the organ, where there is a meso-appendix. The road by which infection reaches the peritoneum from the mucous lining is thus explained.

The various positions and the relations of the appendix to the caecum and the pericecal fosse are described. These fosse should always be carefully explored when the appendix cannot be found in its commoner positions, and cases are quoted in which the author has found the organ in these fosse. It must be remembered that the mouths of these fosse may be more or less obliterated, and difficult to find. The author thinks that the appendix is never absent, except as a result of disease, and the reason why some surgeons have failed to find it is to be found in these facts.

The distribution of blood-vessels and lymphatics helps to explain the symptoms and signs of the disease, and is worthy of being carefully studied.

Cases of appendicitis are classified according to their pathology and morbid anatomy into the following groups: (1) appendicitis with ulceration of the mucosa; (2) appendicitis with ulceration of the mucosa and bacterial invasion; (3) appendicitis with ulceration of the mucosa, and with faecal concretions, foreign bodies, and their complications; (4) appendicitis with stenosis and its complications, cysts, mucocoe, empyema, ulceration, and bacterial invasion; (5) appendicitis with sclerosis and obliteration of the lumen; (6) appendicitis with lymphangitis and lymphadenitis; (7) appendicitis complicating malignant and other diseases; (8) tuberculous appendicitis, actinomycotic appendicitis. Illustrative cases of each variety are given, with an explanation of the symptoms from the morbid appearances. It is clearly proved that faecal concretions are the result of bacterial growth and are masses of bacteria, and to this is due their evil properties. There is so much that is of importance in this part of the book, that it is almost impossible to single out any one part without appearing to neglect the rest. It is interesting to note that, though tuberculosis of the intestinal tract and peritoneum is so frequent, in only three out of eighty-three cases (in all of which tubercle bacilli were looked for) was tuberculous disease of the appendix found, and in each of these cases there was tubercle elsewhere. It would be difficult to say how much of the symptoms were due to the appendicitis, and how much to the tuberculous peritonitis. It may be desirable and quite justifiable to remove the appendix in such cases, as it may be full of pus and rupture into the peritoneal cavity.

The author considers that "rather an exaggerated importance is given to the presence or absence of pus. The formation of pus may sometimes be a favourable sign, and some of the most rapidly fatal forms of peritonitis run their course without any having been formed. . . . Something depends on the nature of the infecting organisms." The *Bacterium coli commune* is the one most frequently found; it is not necessarily the most harmful. It gives rise to the offensive odour and gas so commonly found in the abscess. Other organisms frequently found with it are *Streptococcus pyogenes* and *Staphylococcus aureus*, both of which are well known to be virulent. The peritoneum itself is an important factor, and "when the suppuration is circumscribed by firm fibrinous adhesions we may infer that the infection is not virulent, that the peritoneum is resistant, and that these favourable conditions will persist after the operation."

Discussing the symptoms, the author points out that, "a point beneath the right linea semilunaris, about on a level with anterior superior spine of the ilium, is often the most painful spot, and is the most tender on pressure." But I have found it unsafe to assume that the appendix will always be found beneath the spot which is said to be painful on pressure. The importance of an examination *per rectum* in every case is insisted upon: vaginal examination is not so valuable, because the extent of peritoneum which can be reached by this method is small. We think that it is a method which should always be employed, whenever possible, as an aid to the differential diagnosis of salpingitis and ovaritis. Another important fact is that no tumour, as a rule, exists in acute infective appendicitis with gangrene or perforating ulcer; the discovery of a tumour in severe cases is rather favourable than otherwise.

The value of the pulse as an indication of the course and prognosis of the attack is insisted upon and illustrated by cases. We agree that no "time limit" should be laid down when to operate in acute cases.

In discussing the differential diagnosis, we are surprised that more stress is not laid on the similarity of acute appendicitis and perforation of a gastric or duodenal ulcer. We have seen several cases in which perforation of a gastric ulcer has been diagnosed, and at the operation the appendix was found to be perforated or gangrenous.

Our author is in favour of removing the appendix in cases of appendicitis with abscess; (1) because it may be in a state of acute sepsis, and contain a concretion or foreign body; (2) it may keep open a septic sinus; (3) after being quiescent it may be capable of causing a fresh attack. He also considers the dangers of infecting fresh areas of peritoneum are exaggerated. In cases of diffuse peritonitis he removes any pus or lymph with sponges, and washes out the peritoneal cavity with abundance of lotion (biniodide of mercury, 1 in 1000 or 2000) paying special attention to the flanks, the iliac fosse, the root of the mesentery, and the intestines.

The last chapter deals with the after-treatment of operation cases, and is one of the best in the whole book.



In a short review, such as this, it is impossible to deal adequately with many important points, and many on which opinions will differ. We have tried to indicate the scope of the book, which will well repay careful study. It remains to add that the book is well got up and illustrated. But surely "bauba rigma" is a novel way of spelling "horborygmi."

A MANUAL OF MEDICINE. Edited by W. H. ALICHH, M.D. Vol. II. General Diseases—continued. (Macmillan. Pp. 380. Price 7s. 6d. net.)

The second volume of this Manual preserves the good points we mentioned in reviewing the first volume. The articles are concise, yet well up to date, and they have been put into hands peculiarly fitted for them.

Dr. T. W. Shore contributes the biological section, concerned with the diseases caused by parasites, and we congratulate him upon his lucid and comprehensive accounts, which are nevertheless kept within readable space.

Dr. Rose Bradford's chapters on the "Pathology of the Ductless Glands" include some very valuable epitomes of the most recent views upon this subject, the ideas concerning which are necessarily changing with newly discovered facts.

The "Diseases of the Blood" are discussed by Dr. Coupland, and form one of the best sections of the book.

Some valuable pages are contributed by the Editor upon minor conditions, such as obesity, senility, etc.

Dr. Cuff manages an exceedingly terse chapter on gout without confusing it by undue discussion of rival theories.

We congratulate Dr. Allich upon his last volume.

MEDICAL JURISPRUDENCE. By WILLIAM MCCALLIN, M.D., B.Ch., Barrister-at-Law. Baillière, Tindall, and Cox. Price 4s.

This brief but useful work contains in a concise form most of the information on forensic medicine and toxicology that medical practitioners are likely to require in their everyday practice, or students preparing for their finals are expected to know.

The book is well got up and excellently arranged.

The first part contains a summary of the legal points affecting our profession arranged for ready reference, and differs from most other books of its size in quoting chapter and verse of the legal enactments, and giving examples from leading cases.

The second part deals with the common poisons; here the necessity for brevity has led occasionally to undue compression, but the facts are sufficiently insisted on, the symptoms are described well, the treatment is in a handy form for reference, and the tests for the various poisons given at some length.

We have little hesitation in recommending the book both for purposes of examination and reference.

## Examinations.

### Conjoint Board.

The following have completed the Examinations for M.R.C.S., L.R.C.P.:—T. Young, J. Stirling-Hamilton, R. C. Elmslie, E. C. Mackay, R. H. R. Whitaker, F. E. Murray, E. A. Donaldson-Sim, V. J. Dungan, G. S. A. S. Wynne, R. L. V. Foster, J. C. M. Bailey, W. E. G. Malby, A. H. John, N. C. Beaumont, W. E. G. Boyle, A. Amsden, A. W. C. Lindsey (R. C. P. only).

Anatomy and Physiology.—R. G. Williams, W. H. Hamilton, A. R. Wade, G. D. Drury, A. S. Williams, K. S. Wise, M. F. Grant, W. C. P. Harland, J. G. Atkinson, N. C. Patrick.

Chemistry.—H. C. Waldo, H. N. Wright, A. K. Armstrong, R. C. P. Berryman, G. J. Eady, E. W. D. Hardy, T. A. Kilby, H. J. S. Kimbell, E. S. Marshall, T. O'Neill, E. W. M. Payne, F. L. Wright, A. C. Wroughton, F. H. W. Brewer.

Elementary Biology.—H. C. Waldo, H. N. Wright, A. C. Wroughton, F. H. W. Brewer, R. A. Bowling, H. W. W. Bund, R. V. Favell, W. R. Favell, J. G. Gibb, W. H. Harvey, G. P. Jones, P. Lang, J. R. Lloyd, W. G. Loughborough, C. B. Mora, E. H. Shaw, J. G. Watkins, H. F. Webb-Bowen, F. Whitby, A. C. Wilson, R. C. P. McDonagh.

Practical Pharmacy.—C. W. C. Harvey, L. V. Thurston, G. P. Gill, W. V. Wood, L. U. Geraty.

## Appointments.

BETENSON, W. D., M.R.C.S., L.R.C.P., appointed Plague Officer at Cape Town.

CATHCART, G. E., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Rotherham Hospital and Dispensary.

CLARKE, HUNLEY, M.R.C.S., L.R.C.P., appointed House Surgeon to the Victoria Hospital, Folkestone.

FISHER, C., M.B., B.S.(Durh.), appointed Ship's Surgeon to H.M.S. 'Edro.'

HOGARTH, R. G., F.R.C.S.(Eng.), appointed Senior Assistant Surgeon to the General Hospital, Nottingham.

HUTCHENS, HAROLD JOHN, to be Captain in the Army Medical Corps, Queensland Defence Force (Land).—Queensland Government Gazette, February 20th, 1901.

CAPTAIN HAROLD JOHN HUTCHENS, Army Medical Corps, to be Medical Officer in charge of the 5th Queensland Contingent (Imperial Bushmen) for South Africa.—Queensland Government Gazette, February 21st, 1901.

JOHNSTON, D. M., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Derbyshire Royal Infirmary, Derby.

JONES, EVAN, M.R.C.S., L.R.C.P., appointed House Surgeon to the Cardiff Infirmary.

TURKEL, C. H., M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Royal Halifax Infirmary.

WHITWELL, H., M.R.C.S., L.R.C.P., appointed House Surgeon and Casualty Officer to the Royal Free Hospital.

## New Addresses.

ROUGHTON, J. P., Croft House, Headlands, Kettering.

RUST, J., 30, St. Mary's Road, Higher Crumpsall, Manchester.

PRESTON, F. H., 241, Burrage Road, Woolwich.

EDWARDS, J. H., 114, Marine Parade, Brighton.

HYDE, H. F., West Dean, Queen's Road, West Worthing.

DICKSON, A. W., Stanway House, Stainland, near Darlington.

EVERINGTON, H. D., St. Aubyn's, Glossop Road, Sanderstead.

LINDSAY, A. W. C., 1, Hazellville Road, Hornsey Rise, N.

KLEIN, J., Harewood, Riverdale Gardens, Twickenham Park, Richmond.

MIDELTON, W. J., 72, Charminster Road, Bournemouth.

COCHRANE, A., Superintendent, Lunatic Asylum, Lahore.

## Birth.

STANLEY.—On January 23rd, at Brabourne, Kent, the wife of Herbert Stanley, M.B.(Cantab.), M.R.C.S., L.R.C.P., of a son.

## Marriages.

ANDREW—WOOD.—On April 22nd, 1899, at the Cathedral, Nelson, New Zealand, by the Rev. J. C. Andrew, M.A., Fellow of Lincoln College, Oxford, assisted by Rev. J. P. Komphorne, Philip Oswald, youngest son of John Chapman Andrew, M.A., to Emily Lizzie Maud, only daughter of Browne Wood, Esq., late Indian Civil Service.

NUNN—CHATER.—On February 26th, at Ealing, W., James Henry Francis Nunn, M.R.C.S., L.R.C.P., of Roose House, Upper Tooting, S.W., to Elizabeth, only daughter of James Chater, of Eaton Rise, Ealing.

PRESTON BOWRETT.—On May 8th, at Emmanuel Church, West Hampstead, Francis H. Preston, M.A., M.R.C.S., to Hilda, daughter of the late Thos. E. Bowkett, M.R.C.S.

STEPHENS—SANDYS.—On February 26th, at Meerut, India, J. W. W. Stephens, M.D.(Cantab.), to Mary Sophie, eldest daughter of Lieut.-Colonel Sandys, I.S.C.

# St. Bartholomew's Hospital



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## NOTICE.

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

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## St. Bartholomew's Hospital Journal,

JUNE, 1901.

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

## An Introductory Lecture on Ophthalmic Medicine and Surgery.

Delivered on May 6th, 1901. By W. H. H. JESSOP,  
M.B., F.R.C.S.

(Concluded from p. 115.)

**I** WISH now to bring before your notice a few of the most important points in connection with ophthalmic note-taking.

First and foremost is the vision. This must be taken for each eye separately, and always for distance. The estimation for near vision is not so important, and in many

cases unnecessary. Such a record for distance is absolutely essential if obtainable, not only for the present condition, but in order to have the original vision for reference at a future time. You would be surprised if you knew how many cases one sees, even in well-educated people, armed with the statement that the vision of one eye has suddenly failed, and that the patient is sure he could always see well with that eye. One of the most striking I have seen was that of a barrister who, worried by waiting in a court, involuntarily closed first one eye and then the other, and so found he could not see with the left eye at a distance. Fully convinced he was going blind in that eye, he took the first cab and sought advice. He was thirty-five years of age, and had always been short-sighted with the left eye. The vision in that eye was  $\frac{3}{8}$  — 4 D.  $\frac{2}{3}$ , whereas it was normal in the right eye. One seldom comes across such a case in the male, as most men shoot, and would have found out the difference much earlier in life.

I need hardly remind you of the importance of the present and past history of the patient being accurately taken as to any ocular trouble and refraction errors, and chiefly with regard to the ocular symptoms or signs complained of. Remember that, as so many ophthalmic cases are refraction errors, it is very important to ask if glasses have been worn or not. In note-taking a negative fact recorded is often as important as a positive one. It is necessary to have a definite plan in your mind whilst considering a case; and I think the best is to take the structures in order from the superficial to the deep.

First make a general observation of the patient's eyes, and include in this survey the expression. Next look at the lids, and the action of the extrinsic ocular muscles. Then in most cases more carefully examine in each eye the conjunctiva, especially as to any changes in the conjunctival or subconjunctival vessels, the cornea, anterior chamber, iris, pupil, and lens. These may all be examined by daylight with or without focal illumination. The other and deeper structures must be looked at later by the ophthalmoscope.

In many cases the intra-ocular tension ought to be estimated by palpating the eyeball through the upper lids by means of the two index fingers, as if feeling for fluctuation in a fluid tumour or abscess. You ought never to lose a chance of trying tension, as it is only by continuous practice that your fingers will become educated to discriminate normal tension and the pathological changes of increased or diminished tension.

The two points in note-taking I am desirous of specially considering to-day are vision-testing and the examination of the pupils.

The method of examining for distant vision is to hang the test-types on a wall in a good light, and to place the patient with his back to the light at a distance of six metres from the types. The type must not be too high, and it is convenient to arrange it so that about the fourth line is on a level with the patient's eyes. Each eye must be examined separately, and the eye not being tested should be covered by a card or by an opaque disc in a spectacle frame.

It is necessary to have several sets of test-types, or to make the patient pick out separate letters in the lines. I have known a child read the letters through twice, and then repeat them by heart for the examination of the second eye.

The test-types I show you are the ones as a rule used, and were constructed by Snellen. He found that the most suitable objects for measuring the visual acuity were sets of three parallel lines with interspaces corresponding in thickness to the lines, and the letters are built up in squares corresponding to these lines.

These letters are so constructed that a letter is seen under an angle of five minutes, and each part of a letter (you will notice the letters are built up in small squares) would subtend an angle of one minute. This angle is taken because it corresponds to the smallest retinal image which can be perceived at the macula. You can understand this by remembering that two stars separated by an angular interval of less than one minute would be perceived as one star.

The letters ought not to make words, or to be in sequence, and I think figures should be mixed with the letters.

If you examine these test-types you will find that above each line is a number denoting the distance in metres at which each letter in it would be seen under the visual angle of five minutes. The largest letter, marked 60, would be measured, and should be seen at 60 metres under this angle; the next is 36, and the others in order, 24, 18, 12, 9, 6. This last line, 6, is the usual standard, as six metres is a convenient distance at which the vision should be estimated. Till the metric system in ophthalmology became more general in England the standard distance was 20 ft. The formula for vision (V.) is represented by a vulgar fraction, of which the numerator is the distance at which the types are read, and the denominator the number given

to the letters read, that is the distance at which each is seen under the standard angle of five minutes. Thus  $V = \frac{6}{24}$  means that the letters of the third line are seen at six metres distance.  $V = \frac{6}{60}$  in the same way denotes that the biggest letter is seen at three metres distance. In most test-types now an extra or eighth line is added, and called 5; thus, most emmetropes and many hypermetropes can see  $\frac{6}{5}$ , therefore Landolt has brought out types with even smaller letters, so that a vision of  $\frac{6}{3}$  can be measured.

If the person examined is illiterate, test-types with dots may be used, or Landolt's types composed of a broken circle forming a C, the circles being arranged so that the hiatus is in different positions, and the patient is asked to denote the position of the gap.

Supposing the patient cannot see the biggest letter at six metres, that is P, the vision is less than  $\frac{6}{60}$ ; he is then told to approach the test types, and to stop directly he can see this letter. This distance is then measured, and according to it the vision becomes  $\frac{6}{50}$ ,  $\frac{6}{40}$ ,  $\frac{6}{30}$ ,  $\frac{6}{20}$ , or less than  $\frac{6}{10}$ . If he fails to read  $\frac{6}{10}$ , the greatest distance at which he can count fingers is measured, and the vision is denoted as "counts fingers" as so many metres or centimetres.

It must be remembered that if fingers are held in front of a blackboard the normal eye can perceive them at about 60 metres distance. Movements of the hand can, of course, be more readily perceived than counting figures, and form the next test in the descending scale.

If unable to see large objects, light is thrown into the eye by focal illumination or by the ophthalmoscopic mirror, and the patient is found to have perception of light, or no perception of light, denoted by  $V = p. l.$ , or no p. l. If he has only perception of light he should be tried for projection. This is done by throwing reflected light by means of the ophthalmoscopic mirror on the fundus from above, below, either side, and in front. If the patient recognises the light well, and points to the direction from which the light is coming, the retina is equally light perceptive and the projection is said to be good. If, on the contrary, the light is not perceived, or perceived badly from one direction, the projection of light is bad, and there is then some disease or change in the retina or optic nerve. This is an excessively important test in cataract cases, when the vision is reduced to perception of light, and no fundus details can be seen by the ophthalmoscope.

For the examination of near vision test-types arranged after Snellen's method are used. The patient should be seated with his back to the light, and each eye tried separately. He should be directed to read the smallest type he can at the most convenient distance to himself. As I said before, this test is not so essential or reliable as that for distant vision, as the accommodation mechanism comes into play. It is chiefly useful in myopia, and in cases where fundus changes are present. A patient seeing less

than  $\frac{6}{60}$ , and, at the same time 5 type at close distance, is almost certainly a myope; but if with this same distant vision he cannot see the large-size type, he has probably some pathological changes in the media or fundus of the eye.

The other point in note-taking I want to impress on you is connected with the condition and action of the pupils. I show you here a pupillometer or instrument to measure the size of the pupil, made from an oblong piece of German silver, with semicircular indentations varying from 1 to 10 millimetres, and you can easily measure the size of the pupil by holding the pupillometer to the temporal side of the eye to be estimated. Other pupillometers are arranged as circles, varying from 1 to 10 mm., generally painted black on an ivory ground.

The pupil in a healthy condition should be about 4 mm. in diameter, circular, regular, and its centre slightly to the nasal side of the centre of the cornea. This eccentric position ought to be so slight as to be imperceptible to ordinary observation. The pupils should be equal to one another, though slight differences are met with in normal eyes. A very important point is that each pupil should vary equally with the other under different degrees of illumination. The chief movements of the pupils are associated with contraction and dilatation, and these alterations in size are called contraction and dilatation reflexes.

The important reflexes, except in special cases, are those obtained by light and accommodation or the movements of the eyeball associated with accommodation, and it is those we will now consider.

For accurate observation of the pupils the patient should be placed in a good light, with the face opposite to a window admitting daylight. The observer, standing slightly to the side and before the patient, tells him to look into the far distance, and to avoid fixing a near object. Each pupil is now measured by the pupillometer. For example, we take each pupil as being 4 mm. The left eye is now covered, and the right pupil from a certain amount of light being cut off becomes 4.5 mm. On now uncovering the left eye suddenly the right pupil contracts with the left to under 4 mm., and then they both quickly become 4 mm. as before.

If we now shade both eyes the pupils become 5 mm., and on exposing both to the light they become 3.5 mm., and then regain the original size of 4 mm.

From these experiments you will gather that light affects both pupils, whether it is thrown into one eye or into both. We talk, therefore, of the effect of light when thrown directly into an eye as the direct pupillary reflex, and of its effect on the opposite eye as the consensual pupillary reflex.

The best manner of observing if a pupil acts to the direct light reflex is to cover the opposite eye with a card, and then to hold another card in front of the eye to be observed; on now removing this latter card the pupil ought to contract.

If there is any doubt about this action the patient should be examined in a dark room, and reflected light ought to be thrown into the eye from the ophthalmoscope mirror. In some cases the reflex is so difficult to make out that it is necessary to use a lens to magnify the pupil whilst the observation is being made.

The accommodation reflex or contraction of the pupil to accommodation is best seen on telling the patient to direct his eye downwards and inwards, and look at a near object. It is scarcely noticeable if the eye be turned outwards, and at the same time fixes a near object. The following measurements show these points. Patient looking into the far distance the pupils are 3.5 mm.; on accommodating for an object at 12 cm., and looking down and inwards, the pupils are 2.25 mm.; on relaxation of accommodation the pupils become 4.5 mm.

### With the China Field Force.

By H. B. MEAKIN, I.M.S.

(Concluded from p. 118.)

**F**OR the advance to Peking it was arranged that all heavy kit should be carried in junks on the river, while the Force marched by the road. We were only allowed a modified scale of field hospital, and all this was stowed in the junks, with the exception of what was carried by our three obligatory mules per section. One mule carried pakhals, or large leather bags of water, the second carried a pair of field panniers containing equipment enough to give first aid, or do a small operation, and a store of drugs, and the third carried 80 lbs. of flour representing a day's emergency ration for the whole section.

Each officer was allowed 80 lbs. of kit, to include that of his syce and servant, and this was to be carried in the junks. Our tents were of course left in Tientsin. It was expected that the junks and the column would meet each evening at the camping grounds, but as a matter of fact the junks usually arrived the following morning, just as the march was resumed. The order published in Tientsin before we started, that "officers' messes will be on board the junks," proved to be a masterpiece in practical joking. Another order stating that tow ropes for the junks were to be procured by the officers in charge from sunken junks in the river, was an attempt to add the duties of "diver" to the already so highly varied occupations of the medical officer.

The advance guard—consisting of the 24th P.I.—left Tientsin on the evening of August 3rd, and my section accompanied them. We bivouacked about three miles north of Tientsin, and supplied a good meal to millions of ravenous mosquitos. No lights or fires were allowed,

as we were almost within range of the enemy. The following morning the Russians on our right shelled the Chinese position, but without any apparent effect. In the afternoon our main body arrived, and so did the rain in torrents. We bivouacked again on the Saturday night (August 4th), and started to advance soon after 2 a.m. on the Sunday morning, through dripping crops, in inky darkness, and soaking clothes, to the accompaniment of fine rain.

The discomfort of this must be imagined, it was indescribable.

Almost before dawn the action of Peitsang began, and by full daylight it was at its height. The Japanese, who passed through our camp during the night, and were to have gone further on and turned the enemy's right, changed their direction too soon and made a successful frontal attack, carrying each direction with an *elan* and dash that showed them to be full of pluck. Had they, however, advanced more cautiously they could have secured the same result, with probably less than half their heavy list of casualties. Though not in the attacking line, we came in for a fairly heavy fire, both of shell and rifle, and for some time were busy attending to our wounded. One of the earliest shells killed two Japs and two mules, only a few yards from where we stood, and at one time while crossing an open plain the Chinese gunners mapped the hospital out with shells that fortunately did not burst, or you, Mr. Editor, would have had to go without this copy. I was very glad to have an opportunity of watching the Japanese medical staff at work. Their dressing stations and equipment seemed much like our own, and were admirably managed. I think they have a greater proportion of medical officers to each hospital than we have.

As the Allies advanced the Chinese retired, and soon after midday we were occupying their position—the village of Pei Tsang. It was good to get into camp again and eat, but again the mosquitos and sandflies devoured us, and there was no peace. We treated some Boxer wounded who had suffered from some of our shells, but we had to leave them behind the next morning, and I expect they were "mercifully despatched" by some of our Allies before long. Dead Boxers were plentiful, but wounded Boxers were rarely seen.

The next day's advance commenced in the early morning, and after a very hot and dusty eleven miles along a sandy road our guns were hammering at Yang Tsun, a very strong position, which would have been almost unassailable if it had been properly held. The Chinese have no liking for a steady advance against them, and as the Welsh Fusiliers, 1st Sikhs, and 24th P.I., came steadily on in extended order through thick crops, in the face of a heavy fusillade of shell and bullet, the Chinese left their position and bolted. The hospitals followed behind, picking up the wounded, and carried them on to a position near the

river selected for our camp. The heat was scorching, and in addition to the casualties due to wounds there were several deaths from heat stroke. Considering the numbers who suffered from heat syncope it is surprising that there were not more deaths from this cause.

It was late in the afternoon when we got all our wounded into camp, and dark before we had got them all attended to. Among other operations an arm was amputated, pieces of shell were removed, a compound depressed fracture was raised, and food and nourishment were supplied as quickly as possible. The junks did not reach the camping ground until after midnight, and the want of our hospital baggage was badly felt. Never shall I forget the experience of that day and night. It was a trying time for all of us, but one especially realised that, do what you can, the lot of a man wounded in war is a very hard one. The patients slept in the doolies and morphia was freely given, but there was not much that we could do in that heat and dust to make them comfortable. The difficulty of getting decent water was very great. We took the water from the Pei Ho, which is like nothing so much as a river of pea soup, and precipitated the mud with alum. We then filtered and boiled it, but all this took a long time, and an adequate supply could not be obtained. Many drank the river water in its natural state undeterred by the passage down stream of an occasional corpse.

The next day, July 7th, the Force halted, and we spent the morning preparing junks for the reception of the wounded, and carrying them on board. The junks were then towed down to Tientsin by a stern-wheeler. The Americans had lost heavily the day before, advancing parallel to us and on our right, and it was an impressive sight to see the burial parties marching out. All day the sun roasted us, and the village close by, that might have given us shelter, was in flames. I was never more thankful to see the sun disappear below the horizon.

On the morning of August 8th we started again, and marched to Tsai Tsung, and from there the following day we reached Ho Shi Wu. Here our cavalry overtook some flying Chinese, and were fortunate enough to capture some standards. The Chinese had a magnificently entrenched position at Ho Shi Wu, and had all but completed a huge cutting in the river bank intended to flood the country so that our troops could not advance, and to lower the depth of the already shallow river to such an extent that our junks would have been unable to move. Had they been able to complete this plan they would have seriously delayed the advance of the Allies, but they seemed to desire no further intimacy with our fire, or else our hurried advance disconcerted them, for they fled hastily, leaving their entrenching tools in the trenches, and their food cooking on the fires in the houses. When we got into Ho Shi Wu tea was still hot in the teapots, and there were many evidences of hasty flight in the middle of a meal.

On the following day, August 9th, we did not march till 4.30 p.m., and the junks had time to catch us up. We reached Maton—fifteen miles—at about 1 a.m. The cavalry and guns started some hours before us. This was a most trying march. The heat was intense, the air was saturated with moisture, and the heavy dusty road lay between crops of maize and millet, from twelve to fourteen feet in height, on either side of the road, which effectively prevented any ventilation. Of the cavalry and artillery that started in the heat of the day eight horses died, and we had scarcely got beyond the limits of Ho Shi Wu before men began to fall unconscious on the ground, with purple faces and epileptiform convulsions. The native troops suffered apparently as much as the Europeans, and the work of attending to them kept our hands full. They were freely splashed with water from the chaguis or canvas bags, two of which hang from each dooley, and given a lift in doolies or upon riding mules until they again became able to march. Later in the night as the air became cooler there was less falling out, but it was a most wearisome march.

Shortly after leaving Ho Shi Wu a party of sappers blew up the large Chinese magazine we had left behind. Though we were more than five miles distant at the time the shock of the explosion was tremendous, and I heard men maintain that they had felt a rush of wind, though I did not notice it myself. A huge black column was thrown into the air to a tremendous height, and before long we were thickly powdered with fine particles of ash and dust. It was a wonderful sight.

On arrival at Maton there was some difficulty about the camping ground, and no water was obtainable. The troops were marched into the crops at the side of the road. These were quickly cut and trampled down, the mules were tethered, and the men threw themselves down on the ground and were asleep in a few minutes. Luckily we had provided ourselves with a cooked fowl and some bottles of filtered water at Ho Shi Wu. We needed no sleeping draught, though it began to rain soon after we halted, and continued to do so nearly all night. Early the next morning, August 11th, we moved our camp to the river side and enjoyed a few hours' peace to cook our food comfortably and rest. In the afternoon we recommenced another night march, and reached Chung Chia Wan an hour or so after midnight. It was cooler than the night before and we had fewer fallers out to attend to.

Our stay in Chung Chia Wan was a very short one, and at 9 a.m. the next morning we were on the road again. This time it was the turn of my section to march with the rear-guard and to pick up all who were too done up to be taken on by the hospitals, or for whom there was no means of transport. My doolies and riding mules were all needed almost from the start, and it was 3 p.m. before we reached Tung Chow, only seventeen miles from

Pekin! It was a scorching march and the troops did not stand it well. We passed many fields of luscious water melons and grapes, to which the men helped themselves freely.

In Tung Chow the hospitals were quartered in a Chinese Joss House, and we were given a full day's rest—Monday, August 13th—which was most enjoyable.

During the night of the 13th the rain poured down, but we could distinctly hear the sound of heavy guns in the distance. At the time we thought they indicated a last effort of the Chinese to take the Legations, but they were really the guns of the Russians who had come into action on the east face of Peking.

We were roused at 2 a.m. and marched out soon after along the muddiest of roads. The gunners, especially those of the Naval Brigade, had hard work to get their guns along, but stuck to it manfully, as they always have done. Later in the day the sun came out, and we should have welcomed a little rain to slacken the bite of the heat. All the morning we were getting nearer and nearer to the sound of heavy guns on our right front, and at about 11.30 a.m. we saw the walls of Peking. An intervening village was shelled to dislodge any enemy it might contain, but our entry was practically unopposed, as all the Chinese had been massed to defend the eastern wall against the Russians and Japanese, while we entered by the south-east gate. We were still, however, only inside the Chinese city, and as we neared the walls of the Tartar city there was a good deal of firing, but we got off with very few casualties.

General Gaselee, as everyone knows, entered that part of the Tartar city held by the Legations through a sluice gate, and there were ringing cheers when the safety of the Legations became known outside. Still even after the Legations had been relieved there were plenty of Chinese troops and Boxers on the walls of the city, especially on the high buildings erected over the huge gates, and our guns made excellent practice as they were turned upon them one after another, but the Chinese seldom stayed long enough for the gunners to do much execution. In one particular instance—that of the south gate of the Chinese city—our guns were brought within twelve hundred yards, and the enemy—two Manchu Regiments I am told—having apparently no idea that they were the objective, waited, suggesting rather the dress circle of a theatre than anything else, until the first shell whizzed into them and burst. There was no waiting after that!

This incident ended our day's work, for it was now after 7 p.m. We moved into the "Temple of Heaven" for the night, and having arranged our doolies and unloaded our mules, we fell to on bully beef and biscuits with appetites that couldn't be beaten. The "Temple of Heaven" is a huge high-walled park, of many acres, well wooded and grassed. In the centre is a large raised marble

altar at which the Emperor was in the habit of worshipping Heaven—as The "Son of Heaven"—once a year, on behalf of his people. Around the altar are several temples gaudily decorated inside, but with handsome exteriors. Some are roofed with pale green tiles, and others with tiles of a rich dark blue, that give a very imposing effect in the sunlight. In one of these temples—the one dedicated to Harmony—we located ourselves for the night. I may add that the "Temple of Heaven," by far the best and most suitable camping ground for troops in Peking, was, with admirable forethought, seized by General Gaselee for the British, as soon as Peking was entered, and its possession has since proved of great convenience and use to us.

As a part of the British force was spending the night in the Legations, two miles away from the Temple of Heaven, and as no previous arrangements could of course be made, many found themselves separated from their messes. Servants were inquiring anxiously for their masters, masters for their servants, and correspondents were wandering about in the darkness wondering what had become of their carts. My servant turned up the following afternoon, and all I could ever get out of him was "Bohut ghole chelta huzoor" (there were many bullets flying, your honour), by which I believe he hoped I should think he had been where strife was fiercest, whereas I knew him too well to believe that he ever came within miles of a bullet. However, we soon settled down. Everyone was fed, "and so to sleep," with a last satisfactory reflection that we were in Peking, our march was ended, and, above all, we were not too late.

Yet although we were so happily situated, the sound of heavy guns during the evening told us that fighting was still going on somewhere, and the next morning we learnt that the Japs and Russians had met with very obstinate resistance to their entry, and that at about midnight the Japs pluckily blew in the gate they were attacking and entered the city. It must be remembered that Peking has twenty five miles of wall, and that the gate blown in by the Japs was some miles away from the gate by which the British entered. The Americans came into Peking immediately behind us, and joined in clearing the walls. As for the French, I don't know when they got in, but I fancy it was some time on the following morning. Personally, I certainly saw no French on the day of our entry, and I recall that the evening before we left Tung Chow—August 13th—a French artillery officer, whose battery was just arriving in Tung Chow, hurried up to me and, his face and hands expressing intense interrogation, said excitedly: "Pardon, monsieur, Peking est pris? Peking est pris?"

It was very delightful to wake on the 15th and know that there were no more forced marches in the immediate future, but I fancy that if we had known at the time for how many months we were to wait in Peking the edge would have gone from our enjoyment. The 80 lbs. of baggage which we had left on the junks at Tung Chow reached Peking a few

days after we did, and I need not speak of the delight with which one seized upon a change of clothing. It was a month or more before any of our heavy baggage followed us from Tientsin.

In the early days there was all the interest of seeing Peking and studying the barricades so bravely and skilfully held by the besieged, whose pale faces and clean clothes contrasted so markedly with the sunburnt faces and dirty clothes of Relief column. The women and children showed particularly the effect of the long-continued horrible danger to which they had been exposed and the stunted diet, and it must not be forgotten that they had before them no hope of anything but the most brutal treatment had they fallen into the hands of the Chinese.

For the first fortnight my section was quartered in the Temple of Heaven, and from there several reconnaissances were made to the south-west across the Imperial Deer Park. On one occasion we cleared some Boxers out of a village, and then occurred an incident that seemed out of place except on the Drury Lane stage. A party of about twenty Boxers, decorated with Boxer-red and armed with long, two-handed swords and spears, rose suddenly from the long grass only a few hundred yards in front of us, and executing a sort of *ballet* to slow time and waving their weapons, advanced to attack a patrol of Bengal Lancers. The cavalry horses, terrified by the brandished and glittering spears, could not at first be made to approach the enemy, but curvetted and pranced in an extraordinary manner. It was a strange sight, but it did not last long.

A few moments later a few little heaps of Boxer-red dotting the green grass, and some Boxer blood on the sowars' lances, was all that remained of the Boxer charge. One of our sowars got a spear wound in his hand, and an officer was slightly scratched on the chest. Among the Chinese dead I noticed the body of a small boy who I judged to have been about ten years old. He was wearing a particularly well-made Boxer coat, and, of course, had not been recognised as a child until killed. These men were the true Boxers who have no modern arms, but fight with bows and arrows, swords and spears. They are always decorated with red, either in the form of a red coat or a red cloth tied round the head or waist. They firmly believe themselves to be invulnerable. The Chinese Imperial troops, who make no such claim to invulnerability, were always anxious for the Boxers to go in front when a fight began, and when the Lee-Metford bullet flattened out the Boxers their priests explained to the survivors that they were not really dead, but would come to life again immediately in some other place.

At the end of August I was ordered out with a column that was sent to occupy the railway station at Feng Tai, the junction of the Tientsin and Paotingfu railways and about eight miles from Peking. Our kit was sent after us. The railway had been destroyed piecemeal by the Chinese.

Rails and sleepers had been removed and buried. Engines had been taken to pieces and parts too large to carry away and hide were damaged to an extent that rendered them permanently useless. A party of sappers and miners was sent to Feng Tai and at once commenced the work of repair, but as no new material was available the early days were spent in searching villages for hidden material. This searching took the form of reconnaissances, as much of the material had been carried to a considerable distance from the line, and as the country was at that time by no means free from Boxers, it was unsafe for small parties to go out. Our fortune, however, only brought us in contact with them on a few occasions, when about a dozen of them were killed, with no casualties on our side, but the continuous riding was most enjoyable and healthy work.

The Russians were at work on the Peking side of us and the Japs on the Tientsin side, while the French took charge of the Paotingfu line beyond Liukiachow. We did our best to preserve the peace of Europe and maintain the "Entente cordiale," as far as we were concerned, and saw a good deal of our neighbours.

Towards the end of September I had the good luck to accompany an allied force to Parh Tas Chu, the summer resort of Peking, a valley among the hills, in which were eight temples said to be occupied in force by Boxers. The rendezvous was at Liukiachow, three miles beyond Feng Tai. We marched from there at 2 a.m. in drizzling rain, and reached Parh Tas Chu at about 10 a.m. There was very little fighting, but about thirty Boxers were killed and a machine gun was captured. The temples were looted and blown up by the Allies, and we returned to Peking the following day.

The newspapers have given long descriptions of the looting of Peking, but none that I have read have given, to my mind, anything like an adequate picture of it, and where those whose work is description have fallen short, it would be useless for me to attempt. It was a wonderful and never-to-be-forgotten sight, though very discreditable to the so-called civilisation of the Allies. In fairness to ourselves I must, however, say that, as far as general opinion and personal observation in Peking at the time went, the soldiers of no nation did so little looting, or were kept so well in hand, as those of the British force.

As to the purely medical aspects of the campaign there is little to say, for we were fortunately spared any great amount of sickness. The Germans lost a good many men from typhoid in Peking, but we had few cases and very few deaths, but then we had few white troops, and natives of India rarely take typhoid. The Japs suffered badly from beri beri and dysentery.

Bart's have been well represented in the force. In addition to those whom I have named already, I met Baird with the 16th Bengal Lancers, who came up to Peking soon after the Relief column. Foulkes is in Peking, Douglas is at

Wei Hai Wei in charge of Röntgen rays in No. 1 Native General Hospital. Major Sykes and Evans are on the hospital ship "Carthage." Major Starr, R.A.M.C., is at Wei Hai Wei with the Chinese Regiment. Dudge came out with a field hospital, and Cruddas with some siege train hullocks, but they are both back in India now. W. G. Richards is in Peking with No. 3 Native General Hospital. Of Bart's nurses Miss Waterhouse is in Tientsin and Miss Hislop in Wei Hai Wei. There are probably several other Bart's representatives, but I cannot remember them at the moment of writing.

HAROLD MEAKIN,

PEKIN, Indian Medical Service.  
November, 1900.

### A Case of Complications.

By W. P. S. BRANSON, B.A., M.B., and C. A. S. RIDOUT, M.R.C.S., L.R.C.P.

**M**ARY P.—, æt. 37, married, and a multipara, previously in good health, ceased to menstruate in August, 1900, and at the same time began to be subject to nausea and vomiting. In the light of previous experience she held herself to be pregnant, and the persistence of the amenorrhoea and sickness, with a perceptible increase in her girth during the succeeding eight months, satisfied her of the correctness of her hypothesis.

Therefore, when, on April 19th, 1901, she was seized with violent intermittent abdominal pains, and an increase in sickness, she considered her confinement imminent, and acted accordingly in summoning her doctor and midwife. Her doctor, after examination, pronounced her to be not pregnant, and advised her removal to the hospital.

On the following day, Saturday, April 20th, she was brought to the hospital and admitted.

The note taken on the evening of April 20th runs as follows: Patient is a healthy-looking, well-nourished woman, not in distress, except when from time to time she is attacked by gripping abdominal pain, which she will compare to nothing but the pains of labour.

Pulse 90, regular and soft. Tongue clean. Temp. 99°. Bowels last open naturally on the morning of April 19th.

Chest.—Natural, except for some bulging of the præcordial region. Breasts inactive.

Heart.—Apex-beat ill-defined in the fifth space. Cardiac dulness extends upwards to the second left rib and well beyond the right border of the sternum.

Sounds.—A to-and-fro rub, synchronous with the heart beats, heard over the lower end of the sternum. Heart sounds are themselves natural.

Lungs natural. Abdomen distended and tympanitic. Slightly tender on the left side.

Per vaginam.—Uterus moveable, and apparently enlarged. Not tender.

Urine, greenish, acid, loaded with pus; no blood or bile.

In view of the tympanitic distension of the abdomen a soap enema was given, but was returned unaltered. During the night the patient vomited twice, and on inquiry the next day said she had passed flatus.

During the following day, the 21st, the symptoms abated; there was no vomiting, and the pains, though continuing, were less severe. On this day a second enema, and gr. v of calomel, were given without any relief to the bowels.

On April 22nd the distension of the abdomen was more pronounced, and distended coils of intestine could be made out through

the abdominal wall. Vomiting recurred, and was distinctly feculent. *Urine*, two thirds pus. Pulse 99-100. Cardiac signs unaltered.

Dr. Gee saw the patient; he considered her to be suffering from intestinal obstruction, and Mr. Langton was informed.

Here the medical career of the case ended, and a summary of the unusual series of coincidences that led to her admission to a medical ward, and her retention there for nearly forty-eight hours, with symptoms which seem (after the event) to point so clearly to intestinal obstruction, will not be out of place.

So far as her own mistakes are concerned it was natural enough that the synchronism of her amenorrhoea and sickness should induce her to believe herself pregnant, and that the coincidence of her abdominal pain with the expected, though rather premature, termination of the supposed pregnancy should confirm her in that belief.

From the House Physician's point of view the misleading features of the case were—

1. The previous history of sickness, which discounted the importance of its aggravation.

2. The existence of signs of an extensive pericardial effusion, which afforded a reasonable explanation of the vomiting.

3. The existence of an abundant acid pyuria, combined with tenderness of the left side of the abdomen, which threw suspicion upon the left kidney as the cause of the abdominal pain, and seemed to make a diagnosis of tuberculous nephritis and tuberculous pericarditis a legitimate explanation of the whole case.

4. The natural relief of the bowels on the day of the onset of the abdominal symptoms.

The moral of the case up to this point appears to be this:—That when in any case the signs and symptoms point to disease of various organs, correlation of these symptoms must be attempted with caution.

*The case from its surgical aspect.*—When seen on April 22nd patient's condition appeared serious; her face was drawn and the anxious, and she suffered from severe paroxysms of pain in the abdomen; vomiting was frequent and of a feculent character. Pulse 92, volume and tension fair. Tongue not foul at all, and moist; temperature, 99°.

*Local condition.*—Abdomen distended and coils of intestine plainly visible; palpation revealed no tumour; percussion note was tympanitic; per vaginam—a tender induration is felt in the left anterior fornix, os uteri gives evidence of old laceration; per rectum—nil abnormal discovered. The urine is loaded with pus.

The diagnosis of intestinal obstruction was made and patient was advised to undergo operation immediately.

*Operation.*—April 22nd, 9 p.m. Anesthetic chloroform. A five-inch incision was made in the middle line of the abdomen, just below the umbilicus; on opening the peritoneal cavity distended coils of intestine protruded into the wound; on manual exploration of the interior of the abdomen a constriction around the intestine was discovered, and this on being brought into view proved to be a fibrous band tightly constricting a coil of the small intestine in the lower part of the ileum. This was ligatured in two places with silk and divided. The underlying gut was congested but not ulcerated, and there were signs of old perimetritis around. There was also found a rounded elastic tumour arising from the pelvis and occupying a median situation—it seemed very similar to the urinary bladder, but neither its connections nor its size were explored, owing to the patient's condition. However, a catheter was passed, and after evacuation of a little urine several ounces of pure pus were drawn off.

The left kidney was also explored but was found to be normal. The abdominal wound was then closed with silkworm gut. The abdominal wound was then closed with silkworm gut. Patient was sent back to the ward and her condition improved quickly; her bowels were opened with a loose motion within two hours of the operation, and she showed no serious symptom.

The abdominal wound united by the first intention, but on removing the stitches on May 1st considerable distension of the lower part of the abdomen was noticed and a rounded smooth, soft elastic swelling was felt rising from the pelvis and reaching almost to the umbilicus.

At this time it was noticed that there was a large quantity of pus in patient's urine, which was acid; urine had been little or none for a few days following the operation; a catheter was passed and some pure pus drawn away after a preliminary flow of urine; there was considerable tenderness in the anterior fornix of the vagina and some induration. A soft rubber catheter was tied in for several hours and much pus-laden urine drawn off; patient's temperature rose to 100°6 on May 1st but slowly fell again. A catheter was

passed daily up to May 4th, when Mr. Langton considered it advisable to examine the patient under anesthetic, as the abdominal swelling was not decreasing.

May 4th, second operation. Anesthetic chloroform. Patient was placed in lithotomy position; the urethra, when a soft elastic finger passed into the cavity of the bladder, there seemed to swelling was found to be invaginating the latter; there seemed to be a small orifice connecting this swelling with the bladder, situated on a papilla-like eminence. This swelling was made out to be part of the abdominal wound.

The abdominal wound was then opened at its lower angle and the swelling came into view; it was elastic, not very tense, covered with peritoneum. By a series of Lembert's sutures it was attached to the abdominal wall, and then aspirated, when 3xxx of yellow-brown pus were withdrawn; a drainage tube was inserted and dressings applied.

*Diagnosis.*—Probably a pyosalpinx.

*Progress.*—Satisfactory; drainage was continued for several weeks, and the cavity was irrigated with lotto boracic; it slowly closed and now (June 25th) there remains merely a fistulous track which admits a probe. The urine speedily became free from pus, and the pericardial trouble (*vide* 'Medical Notes') cleared up. Patient has been getting up daily for some time.

*Remarks.*—The case is interesting: (1) From the fact that an entirely new element was introduced into the case by the sudden strangulation of the gut, which at the time somewhat disguised the primary condition of things.

(2) From the character of the tumour, assuming as it did the appearance of the urinary bladder with which it was undoubtedly in communication.

(3) The ease with which the patient was relieved by operation with few or no bad symptoms, although her heart was labouring under the additional disadvantage of pericarditis.

(This case is reported by kind permission of Dr. Gee and Mr. Langton.)

### The Point of Rupture of a Gastric Ulcer.

By GEORGE F. ALDOUS, Assistant Surgeon to the South Devon and East Cornwall Hospital, Plymouth.

It rarely falls to the lot of the surgeon to witness the actual rupture of a gastric ulcer.

The following notes are of a case admitted into the South Devon and East Cornwall Hospital on April 23rd, under the care of my colleague, Mr. Walter Woolcombe.

E. M., æt. 21, was seized with violent pain in the epigastrium about two hours after her midday meal of beef. There was no sickness, and as the pain increased Dr. Ryan, of Devonport, was sent for during the evening; he diagnosed gastric ulcer, and at once sent her to the hospital.

Previously she had suffered from slight attacks of dyspepsia, but not severe enough to seek relief. On April 22nd she had epigastric pain after her beef dinner, but it passed off by tea-time. She had never vomited, had no nausea nor hæmatemesis.

No opiate had been given to her prior to her removal to hospital. I saw her shortly after 9 p.m. on April 23rd, and as the epigastric pain was increasing, and the pulse in frequency, I decided to operate at once. The liver dullness was slightly decreased. On bringing into view a small, punched-out ulcer, one third inch in the stomach into view a small, punched-out ulcer, one third inch in diameter, was seen on the anterior surface covered by the filmiest transparent layer of visceral peritoneum; it looked like a small window in the stomach. At this point the patient strained under the anesthetic and rupture resulted, but outside the abdomen. The wound was packed, and the stitching completed by two layers of Lembert's sutures, superimposed. Her recovery was uneventful.

The chief points of interest in this case are—

1. The absence of hæmatemesis which occurs in 80 per cent. of cases (Mayo-Robson).
2. The fortunate absence of vomiting.
3. The strength of the peritoneum to withstand the action of gastric juice.

### The Old Order.

ON Saturday, June 29th, there was sound of revelry by day, originating from the Great Hall, where the League of St. Bartholomew's Nurses was holding a meeting for business, no doubt, but also for friendly conversation. The stringent rules of the League prevent a detailed account of the proceedings from being reported in the JOURNAL, but we gather that the business was satisfactorily transacted. Of the usefulness of this institution there can be no difference of opinion, and the number of old Bart.'s nurses who came back for the gathering only adds further proof, if it were needed, of its popularity.

But surely times have changed when we see an organisation such as this springing up in our midst, not only having the approval of the matron, but owing its existence and vitality in no small measure to her efforts. The thought of these things leads one to reflect on the old conditions of life and nursing in the Hospital, and the "Orders and Ordinances for the better government of the Hospital of BARTHOLOMEW the lesse," first published in 1580, throw an interesting light on the subject.

The Matron's Charge (perhaps it has altered but little in these three and a quarter centuries) certainly did not contemplate any such relaxation for the nursing staff as the meeting of League provided. In this Charge, after recounting the duties of the matron herself, there are directions for the "governance and order of all the Sisters of this house," where the following paragraph occurs:

"Also at such times as the Sisters shall not be occupied about the poor, ye shall set them to spinning, or doing of some other manner of work that may avoid idleness and be profitable to the poor of this house. Also ye shall receive the flax provided by the Governours of this House, and the same being spun by the Sisters, ye shall commit to the said Governours that they may both put order for the weighing of the same to the Weaver, and for the measuring of it at the returning thereof."

That these directions were carried out is shown by an entry in the Hospital Journals at this date, "Paide and given to the sisters for their good spynning xijd." Seeing that there were twelve sisters at the time, the Governours of the Hospital appear to have believed in moderation in all things.

It is not easy to picture the surprise of the Sisters of 1580 coming back to Smithfield to take part in a League Entertainment, though it might fall in the category of "some other manner of work that may avoid idleness and be profitable to the poor of this house"; but there is sound counsel in another portion of the charge, where the holder of the office is enjoined to "exhort them (the patients) to vertue and temperance, declaring this house to be appointed

for the harbour and succour of the deer members of Christ's body, and not of drunkards, and unthankfull persons."

In those days evidently a house surgeon would have met with sympathy and support from the authorities if he had referred "police cases" elsewhere.

To the Sisters the Charge was even more explicit, for after ordering obedience to the Matron, "who is appointed to bee your chief Governeresse and Ruler," the charge goes on, "Ye shall also faithfully and charitably serve, and help the poor in all their griefes and diseases as well as by keeping them sweet and clean as in giving them their meats and drinks after the most honest and comfortable manner." Evidently in those merry times the sister was in the habit of appropriating the "extras" ordered for the patients. "Also ye shall use unto them good and honest talk such as may comfort and amend them . . . . And above all things see that ye avoid, abhor and detest scoldings and drunkennesse, as most pestilent and filthy vices;" after all it was as well that there should have been no League where such injunctions were necessary.

But in 1580 the management of our hospital (efficient as it must have been, or those stormy days would have brought disaster to it) strikes the modern mind as strange, for after the Governours comes a list of the "Officers of the Hospital."

The Hospiteler.  
The Renter Clerk.  
The Butler.  
The Porter.  
The Matron.  
The Sisters (twelve).  
The Byddles (eight).

The matron and twelve sisters seem to have carried out the whole of the nursing arrangements, which perhaps were not so heavy as now: since, before admitting a patient the surgeons had to satisfy the Hospitaller that he was likely to prove curable, incurable cases being ineligible for admission as in-patients. Moreover, the physicians do not seem to have been in the habit of visiting their patients in the wards, but sat in state in the hall and had the sick poor brought before them. The moral and religious welfare of the in-patients appears to have been the first care, and after that the relief, if possible, of their bodily ailments. The Hospitaller was the resident at that time who visited the patients, and in all the charges, including that to the surgeons, there is mention made of the duty of ministering to their spiritual needs, for although the relief of poverty and sickness were the objects of the Hospital, possibly more poverty than sickness found admission to the wards. Under such circumstances nursing may luckily not have been of such importance as it is to-day.


Whatever the conditions that obtained in those earlier

days, it is certain that, with the increase of skill in treatment, the need for careful nursing became gradually greater, though it was not until very recent years that there was any possibility of procuring the necessary attentions for the patients.

The institution of this Nurses' League marked a new era in the hospital—its continued prosperity provides a guarantee that there will be no return to the former conditions when "xij<sup>d</sup>. were payde to the sisters for their good spyning."

**In Memoriam.**

ROBERT FORD.

 N May 26th, 1901, at his home in Stroud Green, Mr. Robert Ford, of the Royal General Dispensary, Bartholomew Close, died of Bright's disease at the age of fifty-three.

Born at Ivybridge, in Devon, Mr. Ford had been connected with the Dispensary for the last twenty-seven years. During this time about a thousand Bart.'s men had learnt from him the principles of *Materia Medica*.

In this subject—not one, perhaps, which is apt to command the interest of the average student—he excelled as a teacher, and his *Memoria technica* imbued the dry details of the work with a lasting spirit.

His personality and unflinching kindness won for him many friends among those who were fortunate enough to pass through his hands while preparing for their examinations.

By his death a well-known figure in the Hospital world will be missed. In his life he won the respect of all who knew him. To say that we regret his early decease is but an inadequate expression of our feelings.

**Notes.**

DR. F. J. WALDO has been appointed Coroner for the City of London. He was formerly House Physician to Dr. Southey, and Tutor in Public Health at Bart.'s. Dr. Waldo is, perhaps, best known in connection with public health work. For eight and a half years he has been Medical Officer of Health to the Parish of St. George-the-Martyr, Southwark—a post that has lately been abolished under Mr. Balfour's Metropolitan Boroughs Act. In 1899 he was chosen Milroy Lecturer to the Royal College of Physicians, London. Since the year 1892 Dr. Waldo has held the position of Medical Officer of Health to the Inner and Middle Temples, and in addition to his medical

qualifications he is a barrister-at-law of the Middle Temple.

DR. HERBERT WILLIAMS has been appointed Medical Officer of Health for the Port of London.

DR. NORMAN MOORE has accepted the office of Treasurer to the Abernethian Society.

THE Lawrence Gold Medal and Scholarship has been awarded to C. E. West.

THE Brackenbury Surgical Scholarship has been awarded to A. E. Lister.

THE Matthews Duncan Medal and Prize resulted in R. C. Elmslie and H. Love being adjudged equal. A Medal has been awarded to each.

THE Burrows Prize has been awarded to R. C. Elmslie. The Skynner Prize has been awarded to A. E. Thomas.

THE Junior Scholarships in Anatomy and Biology have been awarded as follows:

- i. E. H. Shaw.
- ii. J. C. Mead.

To see the names of five Bart.'s men in the First Division of the Finals for the London M.B. is a most gratifying spectacle; but this performance was rendered the more creditable by the fact that only twelve candidates in all were placed in the First Division.

UNLUCKILY the weather was not propitious on the afternoon of the Past *v.* Present match, and the number of spectators who found their way to Winchmore Hill was very small; it is not easy to quell a suspicion that Sports are not so enthusiastically supported here as they might be. Our teams are keen, and have been of late very successful in many directions, but the number of Bart.'s men who go to see them perform and cheer them on to victory is reprehensibly small.

If Bart.'s men will read their Journals they cannot plead ignorance of the fixtures as an excuse for non-attendance; which reminds us that the Athletic Sports are to be held on July 12th, at the L.A.C. Ground, Stamford Bridge. A Fulham bus passes the gates, and there is no charge for admission. These attractions are, however, not intended to disguise the fact that, as a rule, a good afternoon's sport is provided, which visitors can watch in great comfort from the Pavilion. There is fresh air and green grass moreover in the neighbourhood.

THE Final Match of the Inter-Hospital Cricket Cup Ties—Bart.'s *v.* Guy's—will be played on the Guy's Ground at Honor Oak, on Thursday and Friday, July 11th and 12th. Trains from London Bridge or Victoria to Honor Oak Park (L.B. & S.C.R.).

OUR ancient institution is being well represented at Henley this year. Etherington-Smith, Payne, and Phillips are in the Leander boat. Graham and Gould are rowing for Kingston R.C.; also Conolly for Twickenham. Doubtless there are others whose names have not reached us.

MRS. WARING has kindly presented a Cup to the Hospital Rifle Club, which will be shot for at the Prize Meeting at Runnymede on July 3rd.

OWING to the munificence of an anonymous donor, the Library is enriched by the addition of a Recording Barometer to its other treasures. It is to be hoped that the weather will in future be regulated to suit the tastes of all.

It is rumoured that conditions of life at Mackenzie's may shortly undergo a startling change, and that Sanitary Science may be called upon to alleviate the sufferings of the Extern and Midwifery Clerks.

CAN it be true that our present system of illumination—that magnificent *lucis a lucendo*—is to give place to some recently invented new-fangled method? It is hardly a matter for congratulation that we should be only now installing electric light into one of the Blocks, but rather we should strive to hide the painful fact that, hitherto, the fitful glow of the gas lamp has made the darkness visible in our midst.

We were recently favoured with a letter asking for our experience of the use of the Tallerman Hot-Air Bath. The letter came under rather suspicious circumstances, and it was housed in the W.P.B. Since then an article in a daily paper has appeared complaining of a boycott of the system by the Medical Profession.

Whatever may be the experience of the treatment in this Hospital, we have only one opinion—and that better left unexpressed—of the strange methods of those interested in puffing the furniture in question.

We have received from the publishers 'A Civilian War Hospital,' being an account of the Portland Hospital in South Africa, written by the various members of its staff. A review will appear shortly in our columns, but in the meantime we would recommend our readers to borrow or buy it, and form their own conclusions. Its interest does not end with the account of the cases treated.

ARRANGEMENT of beds during closing of South Wing:

	Male.	Female.
Sir W. Church	Faith, 22	Mary, 11
Dr. Gee	Hope, 22	Mary, 11
Sir D. Duckworth	John, 21	Coborn, 10
Dr. Hensley	Colston, 22	Coborn, 10
Sir L. Brunton	Kahere, 22	Charity, 11
Dr. Champneys		Charity, 11
	Male.	Female.
Mr. Willett	Pitcairn, 26	Harley, 13
	Paget, 2	Paget, 3
Mr. Langton	Henry, 26	Lucas, 13
	Paget, 2	Paget, 2
Mr. Marsh	Darker, 25	Abernethy, 18
Mr. Butlin	Sitwell, 25	Lucas, 13
	Paget, 3	Paget, 3
Mr. Walsham	Kenton, 26	Harley, 13
	Paget, 2	Paget, 2
Mr. Cumberbatch	Paget, 2	Abernethy, 2

**Amalgamated Clubs.**

CRICKET CLUB.

ST. BART.'S *v.* ADDELESTONE.

Played at Addelestone on Saturday, June 15th, resulted in a win for the Hospital by 178 runs on the first innings; for the Hospital C. A. Anderson played a good innings of 79.

ADDELESTONE.		ST. BART.'S.	
W. Montgomery, c Nealar, b Adam	4	C. F. Nicholas, b Adam	10
A. H. Bell, c Adam, b Stanger-Leathes	0	W. S. Nealar, c and b Montgomery	43
A. E. Darling, b Adam	35	C. H. Anderson, b Montgomery	79
H. Wetton, c Thurston, b Adam	4	L. V. Thurston, c Cobbe, b Henwood	47
J. C. Adam, c Nealar, b Adam	0	H. E. G. Boyle, b Montgomery	14
Rev. W. Williams, b Stanger-Leathes	16	T. M. Body, b Montgomery	11
H. Henwood, b Stanger-Leathes	0	C. H. Adam, not out	17
G. Kilner, b Stanger-Leathes	0	H. E. Stanger-Leathes, b Montgomery	4
J. Cobbett, c and b Adam	5	H. T. Wilson, b Montgomery	5
J. Tulk, b Stanger-Leathes	7	L. L. Phillips, c Darling, b Montgomery	4
Dr. Hope, not out	4	G. F. Page, b Adam	0
Extras	4	Extras	19
Total	75	Total	253

BOWLING ANALYSIS.

Overs.	Maidens.	Runs.	Wickets.
Stanger-Leathes	04	2	23
Adams	0	0	40

SCORES—2nd Innings.

ADDELESTONE.		ST. BART.'S.	
Dr. Hope, b Nicholas	1	F. Cobbett, c Wilson, b Stanger-Leathes	5
W. Montgomery, b Nicholas	6	H. Henwood, b Adams	25
H. Wetton, b Adam	87	J. Tulk, not out	3
A. E. Darling, c Nicholas, b Stanger-Leathes	56	Rev. W. Williams, not out	1
A. H. Bell, c Nealar, b Adam	24	Extras	14
J. C. Adam, c and b Stanger-Leathes	12	Total	253
G. Kilner, c and b Adam	19		

BOWLING ANALYSIS.

Table with columns: Overs, Maidens, Runs, Wickets. Rows: Royle, Nicholas, Nealor, Page, Adam, Stanger-Leathes.

ST. BART'S v. RICHMOND.

Played at Richmond on May 25th.

SCORES.

Table showing scores for Richmond and St. Bart's. Includes names like A. S. Bull, W. James, D. N. McAnley, H. B. Denham, W. Williams, H. W. Lester, W. Adam, W. R. Higson, W. Adam, W. Furze, H. A. Dixon, Greenfield, E. H. C. Henderson, Anderson, Extras, Total.

BOWLING ANALYSIS.

Table with columns: Overs, Maidens, Runs, Wickets. Rows: Stanger-Leathes, Adam, Howell, Page, Anderson.

ST. BART'S v. ST. THOMAS'S HOSPITAL.

The first round of the Cup ties was played at Honor Oak on Thursday, May 29th, and resulted in a win for Bart's by 170 runs. Bart's batted first on a good wicket, and totalled 406 for the loss of 6 wickets. W. S. Nealor played an admirable innings of 174. C. M. H. Howell was unlucky in being run out after making 87 in excellent style. W. E. Honiball also played a good innings of 64, which included thirteen 4's.

SCORES.

Table showing scores for St. Bart's and St. Thomas's. Includes names like H. C. M. H. Howell, H. N. Burroughes, W. S. Nealor, W. E. Honiball, C. A. Anderson, L. Orton, C. F. Nicholas, H. T. Wilson, G. R. Gibbs, G. H. Adam, H. E. Stanger-Leathes, G. F. Page, Extras, Total.

BOWLING ANALYSIS.

Table with columns: Overs, Maidens, Runs, Wickets. Rows: Stanger-Leathes, Adam, Honiball, Howell, Nealor, Page, Anderson.

ST. BART'S v. ST. MARY'S HOSPITAL.

The second round of the Cup competition was played at Chiswick Park on Friday, and resulted in a win for Bart's by 4 wickets and 51 runs. St. Mary's batted first on a somewhat bumpy wicket, and were dismissed for 174. Bart's then made 225 for the loss of 6 wickets, of which H. N. Burroughes scored 101 (not out) in excellent style.

SCORES.

Table showing scores for St. Mary's and St. Bart's. Includes names like G. C. Hobbs, E. P. G. Causton, C. B. Norman, C. R. Worthington, A. V. Sadgwick, H. S. Allerhead, C. D. Carey, F. H. Allerhead, Adam, W. S. Mitchell, S. Nix, h Adam, Extras, Total.

BOWLING ANALYSIS.

Table with columns: Overs, Maidens, Runs, Wickets. Rows: Stanger-Leathes, Honiball, Adam, Howell, Anderson, Page.

PAST v. PRESENT.

Played at Winchmore Hill on Wednesday, June 12th, and resulted in a win for the Present by 70 runs. For the Past W. G. Heasman played a good innings of 65; while for the Present H. N. Burroughes, 51, W. E. Honiball, 44, C. A. Anderson, 48, batted best.

SCORES.

Table showing scores for Past and Present. Includes names like W. G. Heasman, H. E. Scoones, W. S. Randolph, H. S. Greaves, J. W. Nunn, H. Howell, F. H. E. G. Boyle, H. W. Pank, L. B. Rawling, T. Body, H. T. Wilson, W. Malden, Extras, Total.

BOWLING ANALYSIS.

Table with columns: Overs, Maidens, Runs, Wickets. Rows: Stanger-Leathes, Adam, Honiball, Page, Howell, Anderson.

ST. BART'S v. WALDEGRAVE PARK.

Table showing scores for St. Bart's and Waldegrave Park. Includes names like C. F. Nicholas, H. E. Stanger-Leathes, W. S. Nealor, H. N. Burroughes, G. G. Ellett, G. H. Adam, C. A. Anderson, A. H. Bostock, L. V. Thurston, F. Lloyd, G. F. Page, Extras, Total.

BOWLING ANALYSIS.

Table with columns: Overs, Maidens, Runs, Wickets. Rows: Page, Adam, Nicholas, Nealor, Anderson, Burroughes.

ST. BART'S v. M.C.C.

Played at Winchmore Hill, resulted in an easy win for M.C.C. Scores:—

Table showing scores for M.C.C. and St. Bart's. Includes names like L. A. Druce, T. O. Bevington, E. C. Lee, R. H. Malten, A. Watson, G. G. Hearn, Oates, B. O. Bircham, C. B. Hulston, G. Denison, C. G. Hulston, Extras, Total.

BOWLING ANALYSIS.

Table with columns: Overs, Maidens, Runs, Wickets. Rows: Stanger-Leathes, Adam, Howell, Page, Burroughes, Scoones, Nicholas, Phillips.

SWIMMING CLUB.

St. Bartholomew's Hospital v. Oxford University.—This match was played at Oxford on Saturday, June 8th, and resulted in a win for Oxford University by seven goals to nil. In the first half Bart's defended the deep end. Stone was first on the ball and after some good play between the hospital forwards and the Oxford backs Dean obtained possession and started to swim up the bath, but being closely followed he did not attempt to score but passed to Lindsay who scored the first goal with a good shot, Dix just failing to save it. Soon after restarting Dean tried a shot, but the ball fell short, and a few minutes later Lindsay scored again with a hard handed shot. Bart's then pressed Stone, trying a shot at goal from a good pass by Blossome, which Eberle saved nicely. Shortly afterwards Lindsay added another goal for Oxford, as also did Lloyd, and half-time arrived, with Oxford leading by four goals to nil. During the second half the hospital goal was frequently attacked, but Dix, ably assisted by the backs, prevented Oxford from scoring (for some time). However, Lindsay added one more goal after some fine play, and from a corner throw Lloyd was enabled to score again. Even play resulted till near the end, when, just on the call of time Lloyd scored the last goal. Teams: St. Bart's.—C. Dix (goal); V. C. Upton, H. M. Hanschell (backs); A. H. Blossome (capt. half back); R. C. McDonagh, D. M. Stone and J. G. Watkins (forwards).

Oxford University.—H. Eberle (goal); H. R. Dean and C. Hill (backs); H. C. Verney (half back); C. M. Lindsay, C. M. Lloyd (capt.), and H. D. Turnbull (forwards).

United Hospitals v. Cambridge University.—This match was played at St. George's Baths, Buckingham Palace Road, on Monday afternoon, June 10th, and resulted in a win for the Hospitals by two goals to nil. The game was very fast throughout and was marked by some good play on both sides. Amongst the Hospital forwards there was some lack of combination which accounted for the small score. In the first half nothing was scored, as the Cambridge defence was very good, despite the fact that Wallace tried repeatedly to score. During the second half the game was almost entirely confined to an attack on the Cambridge goal. From a good pass by Newby-Smith, Wallace was enabled to score the first goal after a few minutes' play. Shortly afterwards Wallace again obtained possession, and swimming right up to the Cambridge goal, tried a backhanded shot, which hit the goal-keeper on the head and bounced out; however, Wallace immediately got hold of the ball, and being close to the goal had no difficulty in scoring the second goal. Time was called soon afterwards, with no further addition to the score. Team:—

United Hospitals.—C. Dix, St. Bart's (goal); R. Newby-Smith, London, and V. R. Nesfield, St. Mary's (capt. backs); A. H. Blossome, St. Bart's (half back); O. Jevors, St. Mary's; C. M. Hughes, Westminster, and J. Wallace, St. Thomas's (forwards). Prior to the match there was a sixty yards team race of four a side, which was won by the United Hospitals by four yards. The following represented the United Hospitals:—V. B. Nesfield, St. Mary's; D. M. Stone, St. Bart's; C. M. Hughes, Westminster, and J. Wallace, St. Thomas's.

St. Bart's v. Richmond S.C.—This match was played at Richmond on Monday evening, June 10th, and ended in a win for Richmond by seven goals to nil. The Hospital was unfortunately without the services of A. H. Blossome, who was unavoidably absent, and his absence made a good deal of difference to the combination of the team. Richmond were by far the faster lot, Saunders repeatedly getting away and scoring several times. St. Bart's defended the deep end first and soon after the start Saunders scored a goal which he repeated a few minutes later. Stone then tried a shot at our opponents' goal, but the ball fell short, and half-time arrived after Richmond had scored another goal. During the second half four more goals were added to the Richmond score through the medium of Grenville and Saunders, and time was called, leaving Richmond easy winners. Team:—

St. Bart's.—C. Dix (goal); H. M. Hanschell and G. T. Verrey (backs); V. C. Upton (half back); J. G. Watkins, D. M. Stone, and R. C. McDonagh (forwards).

TOUR OF THE UNITED HOSPITALS TO DUBLIN.

Last year the United Hospitals had the pleasure of making the acquaintance of Dublin University, when a match was played between these teams at St. George's Baths in London, and this year it was arranged, chiefly owing to the interest of the President of the United Hospitals, Dr. Morgan Dockrell, that the United Hospitals should play a return match against Dublin University in Dublin.

Thanks to the energy of the United Hospitals' hon. secretary, O. Jevors, of St. Mary's Hospital, the arrangements were well carried out, and another match was arranged against Sandycove S.C. (Dublin (the Leinster League champions). The Hospitals crossed over to Dublin on Thursday, June 13th, and on the next day, the 14th, played against Sandycove S.C., and on Saturday, the 15th, played against Dublin University.

**United Hospitals v. Sandycove.**—This was a well-contested game. In the first half neither side could claim much advantage; the hospital forwards were superior in combination, but the Sandycove team made up for what they lacked in combination by closely marking their opponents. After some fine play, in which Nesfield, Blossome, and Wallace were conspicuous, the latter player, with a hard shot, scored the first goal. Even play resulted till half-time, and the teams crossed over with the Hospitals leading by one goal to nil. On re-starting Sandycove obtained possession, and Conway tried to score, but Dix cleared well. From a good pass by Nesfield Stone obtained possession, and quickly transferring the ball to Wallace, the latter endeavoured to score, but being too closely marked he passed to Jevors, who, with a good shot, scored the second goal. Nothing further occurred and time was called, leaving the Hospitals winners, no stated above.

**United Hospitals.**—C. Dix, St. Bart.'s (goal); R. Newby-Smith, London, and V. B. Nesfield, St. Mary's (capt.) (backs); A. H. Blossome, St. Bart.'s (half-back); O. Jevors, St. Mary's, D. M. Stone, St. Bart.'s, and J. Wallace, St. Thomas's (forwards).

Before the match a team race for 60 yards of four a side was decided, and resulted, after a good race, in a win for the United Hospitals by 3 yards. The Hospitals were represented by Nesfield, Stone, Jevors, and Wallace.

**St. Bart.'s v. Dublin University.** Played before a large number of people, numbering about 150. This was also a very good game, both teams playing up well. The University were first on the ball, and after a good deal of give-and-take play MacCabe obtained possession, and swimming well towards the Hospital's goal he tried a shot, but the ball went wide. The Hospitals then played up, and as the result of some good passing Wallace at last managed to score with a hot shot, after having had two or three shots, which Knapp cleared well. The visitors' goal was several times threatened, but owing to the good defensive play of the Hospital backs the University were prevented from scoring, and half-time arrived with the score of 1 goal in favour of the Hospitals. Soon after the restart MacCabe tried a long shot at goal, but the ball went over the top of the net. For some time nothing was scored, but at last, after a hard struggle, Nesfield passed to Stone, and the latter quickly transferred to Wallace, who added the second goal, Knapp just failing to clear. Time was called soon afterwards, and a very interesting game ended in a win for the United Hospitals, as stated above.

For the visitors Wallace, Nesfield, Stone, and Blossome played well; while M. Dockrell, jun., H. M. Dockrell, Knapp, and MacCabe were the pick of the University team. Teams:

**Dublin University.**—A. E. Knapp (goal); H. M. Dockrell, J. B. Stewart (backs); R. W. MacCabe (capt.) (half back); A. A. Gröno, M. Dockrell, jun., and G. B. Spencer (forwards).

**United Hospitals.**—C. Dix, St. Bart.'s (goal); V. R. Nesfield, St. Mary's (capt.) and R. Newby-Smith, London (backs); A. H. Blossome, St. Bart.'s (half back); J. Wallace, St. Thomas's, D. M. Stone, St. Bart.'s, and O. Jevors, St. Mary's (forwards).

Prior to the match a sixty yards team race was decided, which, after a very good race, especially between Wallace and MacCabe, resulted in a win for Dublin University by one and a half yards, the Hospitals being represented by Nesfield, Jevors, Stone, and Wallace; H. Dockrell, Spencer, M. Dockrell, jun., and MacCabe doing duty for the University.

In the evening the United Hospitals were the guests of the Dublin University, at a dinner held in the Grosvenor Hotel, Dublin, and afterwards adjourned to the Palace Theatre. On June 17th the Hospital men returned to London, after having spent a most enjoyable tour, thanks to the hospitality of the Dublin University.

## LAWN TENNIS CLUB.

ST. BART.'S v. HORNSEY.

Played at Winchmore Hill on Saturday, June 8th, when a weak Hospital team were beaten by 8-0.

## PART V. PRESENT.

Played at Winchmore Hill on Wednesday, June 12th. Rain unfortunately interfered, and prevented a definite conclusion being arrived at. The score at the end was 3-2 in favour of the Present.

A. O'Neill and J. Stirling Hamilton—  
lost to C. H. Barnes and F. H. Wood, 2-1.

H. L. Whale and W. H. Lamplough—  
lost to L. E. Hughes and C. M. Pennefather, 2-1.

F. E. Wood and L. A. W. Pope—  
beat L. R. Tosswill and Paterson, 2-0.  
beat C. H. Barnes and F. H. Wood, 2-1.

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

Played at Cooper's Hill on Saturday, June 15th, and resulted in a win for the Hospital by 5-4 after a most enjoyable game.

J. Stirling Hamilton and L. E. Hughes—  
beat M. Pringle and A. Hicks, 6-3, 6-3.

F. E. Wood and C. A. W. Pope—  
lost to M. Pringle and A. Hicks, 6-4, 7-5.

F. H. Wood and A. Hamilton—  
lost to M. Pringle and A. Hicks, 4-6, 5-7.  
lost to A. Murphy and A. Hicks, 4-6, 1-6.

F. E. Wood and A. Hamilton—  
lost to M. Pringle and A. Hicks, 6-3, 4-6, 5-7.  
lost to A. Murphy and A. Hicks, 2-6, 6-3, 5-7.  
beat P. Fair and H. Oliphant, 6-4, 5-7, 9-7.

## CUP TIES.

Played at Chiswick Park on Wednesday and Thursday, June 19th and 20th. The Hospital team was weakened by the absence of A. O'Neill, who was unable to play. Although we beat Middlesex rather easily on Wednesday the London Hospital defeated us on Thursday, and so we lose possession of the cup which we have held for the past three years.

## ST. BART.'S v. MIDDLESEX.

This match resulted in a win for St. Bart.'s by 12-2.

**Singles.**—C. L. Nedwill beat H. C. Askham, 6-3, 6-3.  
H. L. Whale beat R. E. Pitts, 6-1, 6-1.

L. Orton beat E. T. Harris, 6-0, 6-0.  
J. Stirling Hamilton lost to L. H. Boys, 5-7, 1-6.

C. A. W. Pope lost to Stephens, 6-4, 5-7, 2-6.  
F. E. Wood beat C. McNeil, 6-1, 6-2.

**Doubles.**—Nedwill and Whale beat Askham and Pitts, 6-0, 7-5.  
beat Stephens and McNeil, 6-2, 6-3.

Hamilton and Orton beat Askham and Pitts, 6-3, 6-4.  
beat Harris and Boys, 6-2, 7-5.

Wood and Pope beat Askham and Pitts, 6-1, 6-2.  
beat Harris and Boys, 6-8, 6-4, 6-2.  
beat Stephens and McNeil, 6-0, 6-2.

## ST. BART.'S v. LONDON.

The Hospital team started very badly by losing all the "Singles," and eventually lost by 10-2.

**Singles.**—C. L. Nedwill lost to J. H. Philbrick, 0-6, 1-6.  
H. L. Whale lost to R. C. Mott, 5-7, 0-6.

L. Orton lost to L. Bousfield, 4-6, 1-6.  
J. Stirling Hamilton, lost to H. R. Fisher, 3-6, 1-6.

C. A. W. Pope lost to J. E. Frere, 2-6, 2-6.  
F. E. Wood lost to C. R. P. Hall, 0-6, 2-6.

**Doubles.**—Nedwill and Whale—  
beat Bousfield and Frere, 6-2, 4-6, 6-3.  
lost to Philbrick and Fisher, 4-6, 1-6.

Hamilton and Orton—  
beat Philbrick and Fisher, 6-2, 6-3.  
lost to Mott and Hall, 5-7, 4-6.

Wood and Pope—  
lost to Bousfield and Frere, 7-9, 4-6.  
lost to Mott and Hall, 3-6, 2-6.

## The Summer Concert.



THE Annual Summer Concert given by the members of the Junior Staff and Musical Society was held in the Great Hall on Monday evening, June 24th, where a large number of guests were assembled by invitation. The earlier date of the concert this year resulted in a larger audience than usual, and a very full attendance of the members of the Senior Staff.

Refreshments were served, in the interval between the first and second parts of the concert, in the Square, which was brilliantly illuminated by many coloured Chinese lanterns and fairy lamps, the fountain in the centre being a particularly effective *mise en scène*. The weather, which had been threatening during the day, cleared up in the afternoon, and the night turned out an ideal one, thus enabling the guests to enjoy to the utmost the many delicacies provided for them.

The musical part of the entertainment proved an equally great success.

The Conductor had gathered round him a most efficient orchestra (comprising twenty-six instruments, well balanced), composed chiefly of past and present members of the hospital and their friends, to whom no small thanks are due for their kind assistance.

The precision with which the opening chord of Mozart's overture to "La Clemenza di Tito" was struck must have prepared the audience for a treat—an impression only confirmed by the masterly performance of the old overture, which went without a hitch from beginning to end. The blending of the various instruments was all that could be desired, the wood wind being particularly noticeable for its sweetness of tone; but the intonation of all—strings and brass—was distinctly good. Time, expression, light and shade were carefully attended to, and the overture was brought to a close by a final grand crash on the chord of C major, all the instruments stopping in strict accord with the conductor's beat.

Then followed a song, "The Lass with the delicate air," by Dr. Arne, most delicately sung by Sister Luke, who is possessed of a sweet, bell-like soprano voice of excellent tone. Her enunciation and expression were particularly good, and had it not been that the audience were not yet warmed up to the pitch of enthusiasm, which was subsequently reached, a well-deserved encore would undoubtedly have been insisted upon.

No. 3 on the programme was a violin solo by Mr. Prentice, who evidently has a good instrument and knows how to play it. His rendering of the "Largo," "Aria," and "Giga," by Leclair, who writes in the *Handelian* style, was admirable in every respect. His brought out the tone of the instrument, and the way in which the runs and shakes were performed showed a complete knowledge of technique.

Mr. Bell, who is gifted with a good bass voice, gave an excellent rendering of "Ailsa mine," by Ernest Newton, and as an encore, which was eagerly demanded, sang Maybrick's "Vanity."

The quartette from the "Yeoman of the Guard," "Strange Adventure," which followed, was most effectively rendered by Sisters Luke and Rahere and Messrs. Smith and Nixon, their voices blending well together.

Dr. Samuel West, who is always deservedly popular at these musical entertainments, sang two little gems of Schumann's—"Dichterliebe" and "Wanderlied"—in his sweet tenor voice, with all the delicacy of expression and clear enunciation which usually mark his singing, and as an encore, which there was no resisting, gave the audience an old favourite, "Mary," which was also warmly applauded.

The first part wound up with two part-songs by a chorus of twenty-five voices, who rendered them with every attention to light and shade, and also to time! The result was highly satisfactory.

Part II opened with selections from "Patience" by the orchestra, who played quite as well as in the first piece. Unfortunately, by this time the heat of the hall had affected the pitch of some of the instruments, notably the brass, which somewhat marred what would undoubtedly have otherwise been an excellent performance.

The part songs in Part II were as carefully rendered as in Part I, with the same marked commendable attention to the Conductor's beat which is such a *sine qua non* of good choral singing. The attack in "Since first I saw your face" might with advantage have been a little more precise; but where all was so good it is perhaps a little unkind to be hypercritical.

The other items were three songs; one of which, "Beloved, it is morn," by Florence Aylward, was sung by Nurse March, with such

success that an encore was inevitable, in which she delighted the audience with a very graceful rendering of "Comin' thro' the eye." Mr. J. A. Nixon sang the late Sir Arthur Sullivan's "I would I were a king, fair maid," in good style throughout, and on an encore being loudly demanded responded with "The Border Ballad," Mr. Percival Wood, who was warmly welcomed on his reappearance after an absence in South Africa, also contributed to the pleasure of his hearers by a careful rendering of a ballad by Limpus "To Inez," which received well-merited applause.

The last item on the programme was a chorus by the Junior Staff, "The Lincolnshire Poacher," which the singers apparently enjoyed as much as did the audience, and that is saying much.

"God save the King," by performers and guests, wound up an excellently arranged and well-carried-out Concert; and the thanks of all are due to the energetic Junior Staff Secretaries, Mr. Gillespie and Mr. Gibbins, whose labours were crowned by the weather they procured. The Conductor, Mr. J. A. Nixon, however, deserves rather more than a passing word of thanks, for to those who have had the organising of musical entertainments, more especially where orchestra and chorus are concerned, it is well known that a Conductor must work indefatigably to attain such a degree of excellence as the present concert may fairly claim to have achieved.

Such was evidently the opinion of at least one member of the Junior Staff who, at the close of the performance, presented Mr. Nixon with a bouquet, which a lady, on passing out of the hall declared, *cotte voce*, to be "probably a cabbage," but ocular demonstration proved it to be a veritable bouquet of flowers.

## PROGRAMME.

## PART I.

- Overture . . . "La Clemenza di Tito" . . . . . Mozart  
The Orchestra.
- Song . . . "The Lass with the delicate air" . . . . . Arne  
Sister Luke.
- Violin Solo { (a) Largo . . . . . } Leclair  
{ (b) Aria . . . . . }  
{ (c) Giga . . . . . }
- Song . . . "Ailsa mine" . . . . . Newton  
Mr. Bell.
- Quartette . . . "Strange Adventure" . . . . . Sullivan  
(Yeoman of the Guard)  
Sister Luke, Sister Rahere, Mr. Smith,  
Mr. Nixon.
- Songs . . . { (a) "Dichterliebe" . . . . . } Schumann  
{ (b) "Wanderlied" . . . . . }
- Part Songs { (a) "Orpheus with his lute" . . . . . } Macfarren  
{ (b) "Blow, blow, thou winter wind" . . . . . }

## PART II.

- Selection . . . "Patience" . . . . . Sullivan  
The Orchestra.
  - Song . . . "Beloved, it is morn" . . . . . Florence Aylward  
Nurse March.
  - Song . . . "I would I were a king" . . . . . Sullivan  
Mr. Nixon.
  - Part Songs { (a) "Since first I saw your face" . . . . . Thomas Ford  
{ (b) "The chase" . . . . . } Edward German  
"To Inez" . . . . . Limpus  
Mr. P. Wood.
  - Chorus . . . "The Lincolnshire Poacher" . . . . .  
The Junior Staff.
- "GOD SAVE THE KING."

## Review.

CATECHISM SERIES.—Part I, BOTANY. Part II, ZOOLOGY. (VERTBRATA.) E. and S. LIVINGSTONE. Price 1s. each.

We have received the first two parts of this series; it seems there are others to follow. While acknowledging that the information has been collated from the best authorities, it is not easy to refrain from expressing the opinion that books compiled on this plan, of "question and answer" represent the very lowest grade of intellectual pabulum. The mind fed on such fare is likely to be stunted in its growth, though its owner may prove successful in examinations.



## The Rahere Lodge, No. 2546.

## INSTALLATION MEETING.

**T**HE Installation Meeting of the Rahere Lodge, No. 2546, took place in the Great Hall of St. Bartholomew's Hospital (kindly lent for the occasion by the Treasurer and Almoners) on Tuesday, June 11th, 1901. Mr. Sydney R. Scott, M.B.Lond., was initiated into Freemasonry, and Bros. Waring, Cross, and Robinson were elected members of the Standing Committee.

W. Bro. Gripper, M.B., the outgoing W.M., installed his successor W. Bro. Phineas S. Abraham, M.D., as W.M. for the ensuing year. W. Bro. Abraham then invested as his officers Bros. W. Gripper, G. H. R. Holden, E. Clarke, Rev. Sir Borradaile Savory, Bart., Clement Godson, D'Arcy Power, C. R. Lockwood, Haig Brodie, G. H. Gilbertson, Howard Marsh, A. G. R. Foulerton, G. H. Robinson, Mus. Bac., H. D. Lauchlan, M. J. Anderson, J. Valérie, J. Herbert Menzies, and P. F. Madden.

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

The report of the Audit Committee was received and adopted. It showed that the amount given in charity during the past year amounted to £69 0s.

A grant of Twenty Guineas was made to the British Medical Benevolent Fund.

At the request of Bro. Chisholm Williams the petition for the formation of the Chisleiden (St. Thomas's Hospital) Lodge was signed by the W.M. and Wardens.

The banquet was held at Frascatti's Restaurant, and attended by eighty-six Brethren. A most enjoyable evening was spent, an excellent musical entertainment being provided by Bros. Courtice Pounds, Franklin Clive, W. L. Barrett, and others.

## Calendar.

July, 1901.

Tues.,	July	2.	Sir Dyce Duckworth and Mr. Marsh's duty. Conjoint Board Final Examinations begin.
Wed.,	"	3.	Mr. Walsham's Clinical Lecture at 2.45 p.m. Cricket v. East Molesey, at East Molesey. Swimming v. London Scottish R.V., at St. George's Baths.
Thurs.,	"	4.	Examination for Shuter Scholarship.
Fri.,	"	5.	Dr. Hensley and Mr. Butlin's duty.
Tues.,	"	6.	Dr. Hensley's Clinical Lecture at 1 p.m.
Sat.,	"	6.	Cricket v. Hampstead, at Hampstead.
Tues.,	"	9.	Sir Lauder Brunton and Mr. Walsham's duty.
Wed.,	"	10.	Mr. Walsham's Clinical Lecture at 2.45 p.m.
Fri.,	"	12.	Sir William Church and Mr. Willett's duty. Sir Lauder Brunton's Clinical Lecture at 1 p.m. Athletic Sports at Stamford Bridge.
Sat.,	"	13.	Cricket v. R.I.E.C., at Cooper's Hill.
Tues.,	"	16.	Dr. Gee and Mr. Langton's duty.
Wed.,	"	17.	Mr. Walsham's Clinical Lecture at 2.45 p.m.
Fri.,	"	19.	Sir Dyce Duckworth and Mr. Marsh's duty.
Sat.,	"	20.	Cricket v. Surbiton, at Surbiton.
Tues.,	"	23.	Dr. Hensley and Mr. Butlin's duty.
Thurs.,	"	25.	Junior Scholarship Examination.
Fri.,	"	26.	Summer Session ends.
Tues.,	"	30.	Sir Lauder Brunton and Mr. Walsham's duty. Sir William Church and Mr. Willett's duty.

## Examinations.

## UNIVERSITY OF CAMBRIDGE.

## Second Examination.—Anatomy and Physiology.

C. E. A. Armitage, H. Beckton, H. J. D. Birkett, A. W. D. Coventon, W. C. Cripps, F. M. Gardner-Medwin, M. F. Grant, E. Harrison, N. C. Patrick, G. L. Ranking, A. C. Warren.

Pharmaceutical Chemistry.—H. Beckton, T. J. Faulder, H. Gauvain, H. N. Gould.

## Third Examination.—Surgery and Midwifery.

F. H. M. A. Beckett, G. V. Bull, F. N. Carroll, H. L. P. Hulbert, W. W. Jendwine, G. E. Loveday, J. McBryde, A. E. Naish, C. de C. Pellier, G. H. L. Whale, F. E. Wood.

Medicine.—H. Gordon-Smith, A. S. Mellor, F. E. Murray, G. H. Orton, F. K. Weaver.

## UNIVERSITY OF LONDON.

## M.B. Examination.—First Division.

A. Eastwood, T. Hampton, J. F. Jennings, W. T. Rowe, H. S. Ward.

Second Division.—J. C. M. Bailey, F. C. Borrow, F. A. Field, J. A. Lloyd, L. F. Marks, J. C. Marshall, C. H. D. Robbs, F. N. White.

## Appointments.

BURD, C. P., M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the Children's Hospital, Newcastle-on-Tyne.

ELWORTHY, H. S., appointed Casualty Officer to the Great Northern Central Hospital.

MALIM, J. W., M.B., B.C.(Cantab.), appointed Casualty House Surgeon at the Bristol General Hospital.

## New Addresses.

CALVERLEY, J. E. G., Claremont House, Cheriton Road, Folkestone.

COVENTON, C. A., 111, Woodstock Road, Oxford.

JAMES, AKHUR, 69, Gloucester Terrace, Hyde Park, W.

MYERS, BERNARD, Haydon House, Goldhurst Terrace, West Hampstead.

SPICER, W. HOLMES, 5, Wimpole Street, W.

WILKINSON, E. S., London County Asylum, Colney Hatch, N.

## Marriages.

ANSTEY-CHAVE—MAIRIS.—On Monday, June 17th, at St. Mary's Church, Queenstown, by the Rev. Canon Daunt, T. Anstey-Chave, M.B.Lond., F.R.C.S.E., of 19, Windsor Esplanade, Cardiff, elder son of W. F. Chave, J.P., the Moor House, Hereford, to Florence Kathleen Victoria, third daughter of V. Mairis, Relvely, Queenstown, and grand-daughter of the late General Mairis, R.E.

KNIGHT—DYSON.—On June 18th, at Rotherham Parish Church, Henry Ernest Knight, M.D.Lond., of Rotherham, to Florence Mary, second daughter of Robert Dyson, J.P., also of Rotherham.

PRATT—EVANS.—On June 5th, at All Saints' Church, Oystermouth, by the Rev. Harold Williams, Eldon Pratt, M.D., of Cardiff, son of the late George Pratt, of Northdene, Streatham Common, to Florence, daughter of the late John Ivor Evans, of Swansea and Westcross.

## St. Bartholomew's Hospital



## JOURNAL.

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## NOTICE.

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

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

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

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

## St. Bartholomew's Hospital Journal,

JULY, 1901.

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

## A Clinical Lecture.

By DR. HENSLEY.

**G**ENTLEMEN,—I propose to call your attention to-day to a case of considerable interest which is under my care in Colston Ward at the present time, in which we have had the opportunity of seeing great changes take place while he has been under observation.

The case is one of a man aged thirty, a fireman (in gas-works), who was admitted to Colston on June 8th this year. The history of his troubles only dates back to last Christ-

mas, when he seems to have had some cough and difficulty of breathing; this increased gradually, and for some months he has not felt fit for his work, which involves very heavy manual labour.

During this time he has had vague pains about the chest which perhaps ought not to be considered to have any connection with his present condition.

So far as his family history is concerned there is evidence of a good deal of tubercular disease among his near relations.

His condition when first admitted was as follows:—A well-made, powerful man, rather drawn about the face, his tongue clean, his respirations natural and easy, 24, pulse 72, good volume, equal in the two wrists, arteries not thickened. Temperature normal. We may consider that on the whole there was nothing much to note about his aspect except that he did not look quite so robust and healthy as a working man should.

On examining his chest no abnormal dilatation of the veins was seen; the skin looked healthy, but the movement on the left side was distinctly deficient; the apex beat of the heart was very feeble, scarcely to be seen and barely felt in the fifth interspace about three quarters of an inch to the left of the sternum, rather further in than may be considered normal; the area of cardiac dulness was correspondingly diminished, not extending further to the right than usual, and, if anything, not so high as in the majority of cases. The sounds were clear at the apex, the base, and over the aortic and pulmonary valves; in fact, there were nowhere any abnormal heart sounds.

The right side of the chest on percussion showed good resonance all over, unless it was a little impaired at the upper part of the sternum. The breathing and voice sounds were natural, and the liver dulness reached to the usual limits.

On the left side resonance was said to be normal except at the apex; there was marked impairment in the supra-clavicular region, where there was faint bronchial breathing, but no crepitations or added sounds. The vocal vibration

was a little exaggerated and the vocal resonance modified, being somewhat louder.

As one passed away from the apex the breathing was lost completely; no added sounds were heard, no tinkling, no bell sounds—nothing but absence of breathing.

The heart sounds were not abnormally conducted in any direction.

In the abdomen nothing unnatural was noted, and elsewhere everything was normal.

This was the condition when first seen; when I first saw him two days later I thought the resonance on the left side was somewhat different all over from that on the right, being generally slightly deficient; this, however, was not well marked, otherwise his physical signs were as I have already described.

Here, then, in this case you have four main signs to be interpreted:

1st.—The absence of breathing and voice sounds on the left side except at the apex.

2nd.—The resonance either natural as at first thought, or slightly altered as I found it.

3rd.—The deficient movement.

4th.—The position of the heart whether displaced as a whole to the right, or but slightly displaced to the right, being in the main normal.

Now to pass to a discussion of the diagnosis of the case. The first suggestion was pneumothorax—a view that I believe Dr. Herringham, who saw the case in the first instance, was inclined to adopt; at the time that I saw the man I could not accept this; I thought it was possible, but did not on the whole lean to it.

Taken by itself the absence of breathing on the left side would do for pneumothorax, but in such a case there would at some time be sure to be added sounds—amphoric breathing, tinkling, bell sound, or some reverberatory sounds, perhaps not present at first; but on repeated examination some unnatural sound would almost certainly be heard. It would be most unusual to go on without some variation to attract attention.

Then resonance in pneumothorax, though not different at first, commonly, at one time or another, varies very considerably from that over normal lung; but in this case we never got a high-pitched note as in pneumothorax.

Deficient movement one would expect in pneumothorax, but not early signs of collapse such as were present here. Again, the history was against it; in pneumothorax there has usually been either some indication of chest disease, tubercular or other, for some time past, or a sudden respiratory difficulty, with perhaps a sense of something giving way within the thorax, or both of these.

I think cases without some such signs as these must be rare.

In this instance it seemed to me that the resonance on

the left side must be lung resonance, not pleural; if so, what was the condition giving rise to it?

It would seem most probable that the lung was expanding but little—doing so in such a way that breathing was inaudible; if so, under what conditions does the breathing become inaudible? for this is often the case.

For, apart from incompetence on the part of the auscultator, there are some cases in which the breath sounds are inaudible, sometimes permanently, at others only temporarily.

There are some people whose breathing is so quiet that, under ordinary circumstances, it is very difficult to catch any sound whatever. There are people who in health breathe "as quietly as a cat walks," and others, in other respects apparently normal, who breathe "like a motor car." Apart from these there are some who, temporarily, breathe asymmetrically. I think this asymmetry of breathing occurs not infrequently as a more or less temporary phenomenon among children quite healthy, and may be due to some difference in attitude or to unequal movement of the limbs, so that the breathing is loud on one side and inaudible on the other.

One may, I think, confidently assert that this phenomenon is due to inequality, either of air exchange and movement in the lungs, or of the blood passage through them; all of which may take place within the limits of health.

If inaudible breathing is found under natural conditions it will not require much to bring it about in disease.

The changes that might produce this effect on the lungs may act either circumferentially or upon the trunk parts. Leaving out changes in the lungs that may affect them circumferentially, e.g., emphysema, which affects the distal portions, the air vesicles, one passes to consider the causes that may affect them—I do not like to say necessarily by pressure, but by some action on the trunk parts.

Under such circumstances there is a stage where there is the beginning of collapse, but the condition has not advanced so far as to be complete.

When a lung becomes partly collapsed there are changes in movement; the breathing is intrinsically less and less audible, and, in addition, not so well conducted as in compression of fluid; yet, until the lung is quite empty of air, one may suppose that there is air exchange, but that it is inaudible.

I think there is no doubt you meet with this often in children in whom there are temporary lung collapses.

At times, too, one finds signs of limited collapse which in a short while passes off. I cannot tell why this occurs, but the fact remains: parts of the lungs seem to be, as it were, resting. In children difficulties in the tube, blocking by mucus, and various other changes occur which lead to deficient air entry and partial collapse of the lung beyond. They may arise suddenly with urgent symptoms from im-

pacted foreign bodies, when one would at once recognise a "trunk difficulty," or more gradually without causing immediate distress. The inaudible breathing depends in these cases on "trunk difficulties" and partial collapse slowly operating on the air tubes and on the blood-vessels, perhaps leading to diminished blood flow and consequent adjutory changes in the lungs.

I am inclined, on these grounds, to accept the idea in the case we are discussing that the inaudible breathing was due to "trunk difficulties" acting through the air passages and the blood supply, for one may lose the breath sounds before there are decided signs of pulmonary collapse.

We will now go on to consider the further history of this case.

The patient went on pretty comfortably for the first day or two without pain or difficulty of breathing; no cough or expectoration, the temperature remaining normal.

On June 11th the patient began to complain early in the evening, shortly after his supper, of pains about the chest generally, but commencing in the epigastrium. As this might have been due to dyspepsia he was given a carminative. At 11 p.m. he was in great pain, which he located under the angle of the left scapula, not collapsed, but his face very drawn. Pulse rate and respirations had not altered, but on examining the chest the heart's apex beat was seen just inside the nipple line in the fifth interspace, with obvious pulsation on the left of the sternum extending up to the second rib cartilage on the left. There was no absolute dulness over the præcordium, but a faint systolic bruit was heard over the second and third spaces (left), conducted a short way to the left, and not in any other direction; this was new. The note was more impaired over the whole left side, and there was distinct beginning of dulness at the left base behind near the posterior axillary line.

The stomach resonance reached, perhaps, a little higher than is usual.

Belladonna fomentations were ordered, and he was left until 2 a.m.

At 2 a.m. he was seen again. The pain had increased, and the man was sitting upright in bed, rocking himself to and fro.

His face was very drawn, and the extremities rather cold; the breathing had not altered (still 24), and the pulse rate was unchanged—72, but rather smaller volume. Temperature normal; retching a good deal, and coughing a hard, almost ringing, cough. There was vigorous pulsation found this time on the left side of the sternum, from second rib cartilage to a point one inch outside the nipple line in the fifth space. There was also a loud systolic bruit in the second and third spaces (left) close to the sternum, conducted to the left.

The note over the whole left side was more impaired, and no breath sounds were heard, except at the extreme

apex. The right side of the chest and the abdomen remained natural.

The treatment adopted was a hypodermic injection of morphia, and ice-bag to the chest (the latter he did not tolerate). Things quieted down in a short while, and he remained without change of symptoms during the rest of the night, except for vomiting once.

So he went on until the 14th, when there was very little change in the signs, except that round the root of each lung behind there was a slight alteration in breathing, a faint bronchial character becoming evident; the man himself was much more comfortable.

On June 15th the left radial pulse was thought to be decidedly smaller than the right.

On the 21st he was complaining less of pain in the back, but had it in the left shoulder, shooting down the left arm. His voice was quite hoarse. No dyspnoea. Temperature, pulse, and respirations unchanged. The pulses were only unequal on the one day, the 15th.

Dulness had become more marked on the left side, especially under the outer end of the clavicle, and increasing steadily at the base behind, reaching nearly to the spine of the scapula. There was complete absence of breathing, except at the extreme apex, back and front, and about the root of the lung, where there was a slightly larger area of bronchial breathing than formerly (this alteration was present, too, on the right side).

The area of pulsation in front was not changed, but the heart-sounds were more clearly conducted to the back.

On the whole I considered the left side more airless, without increase of the cardiac indications.

Since July 1st one has been satisfied that there is a definite inequality of the radial pulses. The deficiency in movement on the left side of the chest is more obvious, and the dulness more absolute; the pulsation on the left of the sternum is unchanged, but the systolic murmur is now heard on the right of the sternum in the third space, while the heart-sounds are more loudly conducted to the back; there is an increase in the area of bronchial breathing round the root of both lungs. The stomach resonance is rising higher, and rendering the left base less dull than formerly.

Now, gentlemen, you see from the earlier description one was inclined to ascribe this man's condition to something affecting the trunk parts of the lung—either a growth, an aneurysm, or may be something leading to a partial blocking from within.

All the symptoms noted seem to tend in the direction of aneurysm; but what is the cause of the increasing dullness of the left side?

Collapse partly, no doubt, and increasing fluid in the pleural cavity; I think that the diminished movement would indicate increasing collapse.

Then there has been pain in the back, in the shoulder,

and shooting down the arm, such as one meets with in aneurysm of the last part of the arch and beginning of the descending aorta. Moreover the pulsation, murmur, and inequality of pulses are all in favour of aneurysm; so that I think it not improbable that the patient is suffering from aneurysm, perhaps a dissecting or multiple aneurysm.

As regards the changes that took place that night, on June 11th, we may suppose that some rupture occurred, that there was bleeding from an aneurysm or from the aorta separating the inner and outer coats, which led, not to increased trunk difficulty in the lung, but to an alteration in the position of the heart; for that was the most striking of the new elements introduced. I think we must regard this as a case of aneurysm of the aorta at the further part of the arch, possibly involving also the descending portion, in which there was either an escape of blood from the aneurysm or a fresh break-out of blood in a dissecting aneurysm, leading to a change in the heart's position.

I have looked in the Museum to see whether there is any specimen showing pulmonary collapse from pressure of an aneurysm about the root of the lung, but there is nothing displaying that change; this one, however (No. 1483a), is the nearest approach to such a condition. It is from a case that I had the opportunity of seeing at the City Road Chest Hospital, and it is described in the catalogue as follows:

"Portion of a left lung the upper lobe of which is compressed and destroyed by a large aneurysm. The lower lobe is merely collapsed; the upper lobe is so compressed that it forms but a thin shell, incorporated with the wall of the aneurysmal sac, but still recognisable by its pigmentation. It is airless, dense, and fibrous. The cavity of the aneurysm is filled with laminated clots. It is traversed by an irregular channel, through which the aortic blood-stream flowed.

"From a man, *æt.* 50, who had suffered for three years from shortness of breath and other symptoms pointing to aneurysm. The physical signs were unusual. When the patient came under observation a month before his death there was a round pulsating tumour to the right of the sternum, over which the heart sounds were plainly heard. There was slight uniform bulging over the upper part of the left side of the chest, with absolute dulness to percussion, and a much impaired note lower down. The cardiac impulse could not be felt. The left vocal cord was paralysed. The patient died from rupture of the aneurysm into the left pleura.

"Post mortem it was found that there was an aneurysm of the first part of the arch, which had given rise to the tumour to the right of the sternum. Behind this aneurysm lay the heart entirely to the right of the sternum. The left side of the chest was entirely occupied by a large aneurysm formed by dilatation of the aorta from the second part of the arch to one inch from the diaphragm. This had compressed the upper lobe of the left lung, as shown in the specimen."

This specimen is chiefly interesting as showing how the heart got displaced.

In our case in Colston we have not got anything like this, and in most cases of dissecting aneurysm I cannot find that they led to compression or collapse of the lungs. Death, moreover, usually occurs suddenly, but there is no case in the Museum, nor can I find one recorded elsewhere, in which there was a history like this one, where one may suppose that there had been some escape of blood from

the aneurysm, which the patient got over completely and died long after; though I will not venture to predict that this man, albeit he has recovered from the immediate effects of whatever happened, will survive to a good old age.

### Impressions of a Short Visit to Jamaica.

By L. J. PICTON, M.B.



AT the beginning of the nineteenth century Jamaica was almost a synonym for wealth and luxury. By the end of it England had almost forgotten its existence. The abolition of slavery had produced new conditions of labour which entirely upset the old *regime*; then the competition of beet sugar, supported by bounties, made sugar-cane cultivation on the old lines unprofitable. These two reasons, coupled with the diversion of colonising energy into new channels of the growing Empire, explain the fall of Jamaican prosperity, and how it came to pass that if people at home remembered their West Indian island at all, they thought of her as a poor relation always in difficulties and wanting help.

To a stranger on a brief visit the idea of the island's poverty seems ludicrous. A first view of the mountainous outline, rounded and clothed from shore to peak with trees, conveys an impression of unlimited fertility; and such closer knowledge as is got by long buggy drives into the country seems a lesson in high farming by unaided nature. The ex-slave neither needs nor cares to work much. The soil easily supplies him with yams and plantains; by "working" Wednesday and Thursday he earns a couple of shillings. On Friday he goes off to his "grounds," the little patch he has cleared in the forest by burning the trees, and where he has scratched the soil and planted a few roots. Of these there are more than enough for his own use, and the surplus he sells in the market on Saturday. The remainder of the week he "rests" from these arduous labours. With Friday spent at the grounds, Saturday at market, and Monday and Tuesday in "rest," the week is somewhat curtailed from the point of view of the employer of labour.

The labour difficulty is real enough, but it has been overcome by different persons in different ways. Perhaps the best way is by tactful management and thorough knowledge of the black people. One "busha" or "overseer"—the first word is the corruption of the second—will get absolute and unquestioned obedience from his labourers, where another will be rendered helpless by their irregularity of attendance and entire unreliability. A good busha of the old school will stand at some point which commands a view of his estate, and talk in a conversational tone, appa-

rently to the air, requesting "Mr. So-and-so" to fetch out the Maltese donkey, and "Mr. Somebody-else" to be so good as to take three other men and drive a mob of horses into the yard; and it is not until a couple of black men, who are standing a hundred and fifty yards away, move off and obey the orders, that a stranger realises how much of the wild man's acuteness of hearing remains to the "black people," and to what a degree of dog-like fidelity they can be brought.

At Montpellier good management seems to have solved the labour problem on a large scale. The property has been in the hands of the family who at present own it for over two hundred years, and to judge by the prosperous appearance and respectful manner of the people, and the regularity with which they troop into the tobacco fields when work should begin, the secret of their management has been mastered.

In other parts of the island, however, planters have given up the black people as hopeless, and have been importing coolies from India to take their place. The coolies work regularly, for they are brought by the Government under a system euphemistically called "apprenticeship." The Government sees that they are fed, paid, housed, and put in hospital if sick. When they are well, prison is the only alternative to work. After a term of years they become free once more, and usually return to India with considerable savings. Physically, they are far inferior to the muscular black people, from whom they remain, in dress, manners, and religion, absolutely separate.

The coolies frequently suffer severely with ague, and bad cases of malarial cachexia are sent back to India, the planter paying the £17 passage money. Their finer skin renders the Hindoos more subject than the negroes to the "cane itch," a curious traumatic eczema caused by the friction of the fine saw edge of the sugar-cane leaf.

The disposition of the negro to do no more work than he can help, and to be easily content with a simple life, is a bar to the rapid progress of the island.

It also has, occasionally, two indirect results of some medical interest. The negro is poor in money, so he eats little meat. Yams, plantains, koko roots, and so on, he can have for the trouble of digging them up, the only outlay on agriculture he need make is 1s. 3d. for a "machete" or cutlas, which is at once his pruning hook and spade, and withal his sword, if need be. His diet of vegetables and fruits is fairly plentiful, then, but not very nutritious. Yams are probably pretty near potatoes in chemical constitution, and Burge points out that seven kilos. of the latter must be consumed for 100 grms. of proteid to be absorbed. Again, Hutchison mentions that assuming an average banana weighs 45 grms. without the skin, about 160 bananas would have to be eaten a day to obtain an amount of proteid requisite for physiological equilibrium. Without supposing that the dietary of a Jamaican approaches

these amounts, it is, nevertheless, obvious that to live at all on such fare a very large amount must be eaten; and it is owing to this fact that dilatation of the stomach is a relatively common occurrence among the black people. It is usually accompanied by a very marked melancholy, foreign to the nature of the black.

It is also to their bulky vegetable diet that Jamaican surgeons attribute the frequency of cases of volvulus of the sigmoid flexure amongst the black people. As at home the incidence of this affection is chiefly on middle-aged men; but whilst in England volvulus accounts for 5 per cent. of all cases of intestinal obstruction, in Jamaica it probably constitutes a much larger proportion. Many cases have been operated upon in recent years at the Kingston Hospital, and although it is rare that they are brought for treatment early a large majority of the cases have recovered. One patient, for instance, who had been successfully operated upon for volvulus of the sigmoid of three days' duration in 1896, by Dr. Lockett, was suddenly taken ill again at midnight on October 22nd, 1897. He continued in great distress till the 25th, when he rode five miles on a mule to the District Medical Officer. He was then driven some miles to the capital, when Dr. Lockett once more successfully operated on him.

A group of diseases very common in the Kingstown Hospital has been by custom classified as "malarial neuritis." In the opinion of the present medical officers, however, this diagnosis is certainly wrong; and for these maladies, as for dilated stomach and volvulus, they hold the black man's diet responsible; but in a different way. In this case they suppose the fault lies, not in the bulk, but in the starvation allowance, together with some poisonous quality in the food. Their supposition is built upon the facts that the disease occurs in half-starved individuals, and that it closely resembles the description of the diseases Pellagra and Lathyrism.

Pellagra, as readers of the JOURNAL will recollect, occurs in Lombardy, and is there attributed to a disease of the Indian-corn meal, from which polenta, the staple food of the Italian peasant, is made. Lathyrism occurs in famine time in India, when the people take to eating vetch seeds. In both there are certain nervous disturbances, and in the former, as its name implies ("pelle," skin; "agro," rough), there are trophic lesions. The justice of the comparison between these diseases and the West Indian form, whose identity has been hitherto lost under the title of "malarial neuritis," will be easily seen on considering the features of the latter.\*

It is characterised by symmetrical trophic lesions on the

\* Vide Dr. G. V. Lockett, 'Proceedings of the Jamaica Branch of the British Medical Association,' 1897, p. 25. Since the date of that paper, however, Dr. Lockett has greatly increased our knowledge of the disease.

extensor aspects of the wrists and the front of the ankles, paresthesiæ, diarrhoea, wasting, and anæmia.

It occurs especially in adult females, though it is not infrequent in males. The patients are always poor, and usually half starved.

The skin lesion begins as a "pigmented patch"—brown in the lighter coloured (patients), black in the blacks—resulting in a desquamation by flakes or in small scales, and leaving a pigmented border, which is abrupt on its inner side, and fades imperceptibly into the colour of the skin on its outer side, which border often lasts six months or more" (Lockett).

In addition there is numbness in the hands and feet, and a feeling as if the ground were "spongy," as one patient expressed it. The numbness especially attends the onset of the skin lesions.

There is no actual paralysis, but the patient's movements are ataxic owing to the numbness of the limbs. The knee-jerks are sometimes absent. At the height of the disease the patient is miserably weak and ill, and the skin of the negro, glossy in health, becomes dull. Apathy is very characteristic, and may drift into a permanent melancholia; and a certain proportion of the cases find their way to the lunatic asylum. The lips are dry, but the angles of the mouth sodden. The tongue is glazed, and there is nausea. The belly is tender, and there is watery diarrhoea. Post mortem the gut mucosa is said to be atrophied.

With good food, rest, and care recovery may be complete in two or three months.

Dr. P. O. Malabre stated in conversation that quinine is of no value in the disease, but that arsenic is very useful.

In some cases the disease may begin in the manner described, but come to take on a very different complexion. All the features of a combined sclerosis of the spinal cord may be developed, especially of spastic paraplegia. The difference from the ordinary forms of these diseases consists in the complete or nearly complete recovery of the patient. The cases should, no doubt, be classed as toxic combined scleroses, such as are well known in pellagra.

Though malaria in Jamaica has now been exonerated from the charge of causing these curious food intoxications, it still accounts for a considerable proportion of the illness in that island. It occurs, however, chiefly in the low-lying districts near the coast, especially in the mangrove swamps about the mouth of a river. It may be of interest to mention that the Jamaicans propose to join in the general war that has been declared on the mosquito, by destroying his home, the wild pine. This plant, which resembles a small aloe, is parasitic on forest trees, and is to be seen "manning the yards," so to speak, of the giant cotton trees in every part of the island. The spaces between the bases of the leaves are filled with water by rain and dew, and the thick waxy leaves prevent the sun from drying it up. It is said that

these moist places are the favourite homes of the mosquito, and that to be rid of the pest every wild pine in Jamaica should be destroyed.

Yellow fever, the Vomito prieto (black vomit) of the Spaniard, makes a visitation every now and then to the island, but apparently less often than in former years. It never penetrates to the hills, however, and even an elevation of 1000 feet guarantees comparative safety. Mr. Froude has described the difference between the condition of the troops at Fort Augusta, on the shores of Kingston Harbour, a station which had the reputation of killing the whole of one regiment with the exception of the sergeant-major and a drummer boy, and the high rate of health, but miserably monotonous existence, in the present barracks of the English soldiers, which are literally up in the clouds at Newcastle, a few steep miles from Kingston.

But any precautions are justified against so terrible a disease as yellow fever. Conversation with a physician who has worked through an outbreak of it, and even reading the vivid description of an attack in "Tom Cringle's Log" (Chapters X. and XI.), in which the peculiar mental state of agonised alertness is well brought out, bring forcibly home to one's mind the former conditions of service in the West Indies, conditions which rendered promotion almost as rapid as on a battle-field.

Many cases of the disease called Yaws (Frambœsia) are to be seen in Jamaican hospitals. In March and April last there was a considerable epidemic of it in an orphanage in the capital, for the disease usually affects children, amongst whom it is very contagious. The eruption comes out after about a week of slight fever and rheumatic pains. In the eight or nine cases seen it was scattered over the body, but not on the face. The lesion begins as a branny patch about the size of a threepenny piece. These patches itch and papules appear in them, and burst. The gummy exudation from the papules extends over the whole patch, and dries to form a crust. In six weeks the crust falls off and a pigmented spot is left. The disease is not fatal, though, if sepsis be not maintained, there is danger that severe ulceration may occur. The children recover in a few months or a year.

The chief immediate interest of Jamaican diseases to people in England is from the point of view of Jamaica as a health resort. Those mentioned above, except malaria and yellow fever, are the result of the native conditions of life, and do not affect the "bucra," or pure white person.

But the occurrence of phthisis amongst the natives bears on the question of whether Jamaica's be a suitable climate for the phthisical Englishman. To answer it would require much experience, clinical experiment, and study; but a few facts relative to it may be mentioned. First of all, phthisis does occur amongst the natives, and is rapidly fatal. But the chronic form is practically unknown. The disease is generally of an acute pneumonic type, and runs its whole

course and ends in death in seven or eight weeks. It occurs especially in the half-starved or poorly-nourished. This acute pulmonary tuberculosis is a condition well recognised by Jamaican doctors, but is not particularly common.

Tuberculosis is known to occur amongst cattle in Jamaica; but probably it prevails to a much less extent than in England. Cattle brought into the country must be certified free from the disease after the application of the tuberculin test.

A planter who lives on his beautiful estate on the north side of the island, left England fifty years ago, informed by his physician in the usual traditional manner, that he had perhaps "three months to live,"—"and here I am to-day, sir, and am in the saddle every morning at seven o'clock, which few men over seventy could say." Many other such instances of recovery are to be had on credible authority.

Two districts are especially recommended for consumption patients. One is Malvern, a cool village in the hills, on the south-west side of the island, reached by a sea breeze that is dried and warmed by the hot plain over which it passes. The other is the Blue Mountains. To both the usual means of conveyance is mule-back, and Malvern has the disadvantage that there is no water supply other than that which is collected from rainfall on the barbeques, or great concrete pavements on which the pimento, coffee, and other produce is dried in the sun.

In considering Jamaica as a health resort, the food supplies should be mentioned.

To begin with, dairy produce is not so good as it might be. The butter will not keep, and the only way to get it fresh and good is for the housewife to make it herself immediately before breakfast. There is plenty of time for this as breakfast is at 12 noon.

The milk is rather poor in quality. English Hereford cattle live and prosper tolerably in the island; but they are very apt to get into poor condition, owing to the attacks of the ticks, which swarm in every patch of guinea-grass where cattle are feeding. These ticks, flat-bodied arachnid parasites (*Leptus autumnalis*), are now a serious pest, though fifty years ago the island was comparatively free from them. The introduction of the mongoose to kill the cane-rat had results which were not anticipated. Having disposed of the rat he turned his attention to the birds, which had hitherto kept the ticks down; the balance of nature thus disturbed, the ticks multiplied greatly and over-ran the land; and for his sins the mongoose suffers from them with the rest. The tiny grass-lice, the small red tick, and the silver tick which swells up with blood to the size of a man's fingertip, were carrying on a successful campaign, when their ranks were strengthened suddenly by a powerful ally, the Texan tick, which was brought across on some cattle imported from Texas. He is seven times worse than the rest,

It is more than likely that these arachnids convey cattle diseases from one beast to another. It has, therefore, become a serious problem, urgently requiring solution, how to be rid of the ticks. The mongoose is being killed in some districts, but its extermination seems an almost hopeless task. The tick difficulty has, however, been met to some extent by the introduction of Mysore Cattle. The Indian animals, it seems, in spite of their thinner skins, are less tasteful to the ticks than the English; and the pests leave them unmolested.

It is questionable, however, whether under the best conditions, dairy work will ever be thoroughly satisfactory in Jamaica; and the chief advantage of the Mysore cattle is their success as draught animals.

The meat in the West Indies is tough. It cannot be hung long enough for the rigor mortis to pass off. The Jamaicans, however, get round this difficulty. Miss Kingsley quotes an old gold-coast trader on the subject of the Papaw fruit (*Carica papaya*), "Pap-paws are awfully good for the digestion," he says, "and even if you just hang a tough fowl or a bit of goat in the tree among the leaves, it gets tender in no time, for there is an awful lot of pepsine in pap-paw,"—"which there is not," Miss Kingsley continues, "papaïne being its active principle." The Jamaican's method is to wrap the meat in Papaw-leaves, and leave it in a cool place for a couple of hours. It is tender by then.

The Jamaican menu includes a host of good things: Turtle soup—the turtles are brought to Jamaica from Turk's Island, prawn salad—the prawns live in fresh water streams and are as big as crayfishes, and snapper which is rather like a trout when boiled, are favourite dishes. Land-crabs are also said to be great delicacies.

The Blue Mountain coffee when properly prepared at the house of some planter, deserves its reputation as the best in the world. But the greatest revelation of what an ordinary breakfast table item may be transformed into by artistic methods, is in regard to cocoa. The black people call the plant chocolate to distinguish it from their koko roots. The chocolata fruit is in a pod which grows directly out of the trunk of the little tree. In the pod about three cocoa beans are packed together. These are taken out and dried on a barbecue, or pavement, in the sun. The thin outer shell is then peeled off and the inside part, which is easily crumbled, is boiled for forty-eight hours. The fat comes to the surface, and is skimmed off from time to time. The drink which results is comparable with the best Chinese tea, though with an aroma reminiscent of ordinary chocolate. It is without the ordinary thick quality of cocoa and has not the bitterness of cocoanuts.

Tamarinds, nutmegs, vanilla, ginger of very strong flavour and chiefly used for medicine, castor oil, aloes, pimento or Jamaican pepper—the beautiful groves of dark

foliated pimento trees with their parchment-coloured stems are very characteristic of the northern slopes of the Island—quinine, grape fruit; pine apples, studded all over with their little blue flowers; the garden egg, delicious delicacy when stuffed with mincemeat; mangoes, of which the Number Eleven variety is famous; these and a host of other things, which time would fail me to recount, are yielded by the fertile soil of the West Indies.

A list of fruit is a fitting peroration to an impression of a brief visit to Jamaica, for the retrospect left upon the mind is one in which Nature is seen in her most generous mood.

### A Plague-stricken City.

By J. PRESTON MAXWELL, M.D., F.R.C.S.

IT is just a short month since plague for the first time entered the City of Changpoo. No appropriate setting attended its arrival. There had been lovely weather for weeks, there was no dearth of food, and the streets were full morning, noon, and evening of townsfolk and countryfolk all intent on the business of life. Then a whole family suddenly disappeared, to be quickly followed by several other clearances, death taking place with marvellous rapidity, in some cases under twelve hours from the commencement of the attacks. The rats too began to notify the spread of the disease by their own death. After this the disease slowly but surely settled down on the city. During the first few days the people were incredulous and unbelieving, then as the dreadful fact dawned on them they began to be panic-stricken. Morning, noon, and night the sound of gongs, crackers, and idol processions fell upon one's ear, and the Mandarin went daily in state to one of the temples to try and appease the evil spirits.

As the scourge progressed funerals became a common sight, and in order to avoid depressing the people too much it was ordained that the coffin should always be carried out at the *nearest* gate of the city.

This was the period too of the appearance of a quack remedy, a poor form of tea which sold largely at first.

At the end of fourteen days the seriousness of the matter began to be evident. From that time to the present the streets have become progressively emptier, till now in the afternoon no sign of human life is seen, and in many places the shops are closed. Many of the people stay near their own homes, and dare not go into the city to buy food, obtaining just the bare necessities from itinerant vendors.

Over all the doors the yellow paper supposed to be of use in frightening away the devils is to be seen pasted on.

Then finding that the city idols were useless the Mandarin

had a new one brought in with ceremony from a place fifteen miles away. This was about fourteen days ago, and discovering that it was not working, yesterday a new one was carried in from some thirty miles away, the expense of this procedure being very great.

It is very difficult to estimate the number of deaths per diem in a city like this. At the present time there are approximately fifty to sixty daily. All the burying grounds are full of fresh graves, and the gravediggers for several reasons are doing their work badly, so that some of the coffins are only covered to a depth of a few inches, and the smell in their vicinity is by no means attractive.

Depression has now settled down on the city. The people do not care even to mention the name of the disease, and delude themselves, till well on in the disease, with the idea that it is malarial fever.

In the early days of the scourge I got the Mandarin to put out posters all over the city, telling the people to *clean their houses, kill and burn all rats, and boil all plague-infected clothing*. It is useless to advise the burning of the latter, for they will not do it. But the callousness of the people is extreme. Only a few have followed this advice, and those almost exclusively among the members and adherents of the Chinese Church, who know us and trust us more; none of these up to the present have taken the disease. It is little wonder that it spreads, for in spite of their fear the people will deliberately lie on the same bed as the plague-stricken patient, and sleep under the same coverlet.

As to the medical aspects of the question. It is an undoubted fact that the earlier cases of plague in the city were preceded by the death of one or more rats in the houses attacked. As the plague progressed this connection was lost, but in the first week it was the universal rule. The dead rats were generally found about a week before the attack of the human being, but this time was not constant. Whether or no the infection was carried to the city by rats I do not know, but for three years the disease has been creeping from village to village, following the line of the small waterway that leads to the city. The first few cases appear to have been of a septicæmic type, at least of the first four I was called in to see three were septicæmic and one pneumonic in character.

As to the remedies used. At present we are trying carbolic acid in large doses, and with some success. But into this I hope to enter more fully at the close of the epidemic. Certainly many cases are from the first beyond aid with any of the drugs at our disposal.

The general type of fever I have seen is one which rises rapidly at the commencement to 104°, 105°, or 106°. Some of the cases never come down till death. Others slowly descend by lysis, and there may be a second rise on the occurrence of suppuration in the bubo. But as yet all the buboes I have seen in persons getting well have gone

down under the influence of Empl. Belladonnæ without suppuration.

I hope that this small sketch may enable my readers to realise in some measure what is meant by an invasion of plague, from which one may devoutly pray to be delivered.

### A Case of Cerebral Injury with loss of a Sector in the Visual Fields.

By G. V. BULL, M.B., M.R.C.S.

THE following case is interesting on account of the almost complete recovery following on an unusually severe injury.

On March 14th of this year, a man aged forty-eight was at work on a lift shaft, when he was knocked off and fell about thirty feet on to his head. He was brought up at 6 p.m., collapsed, and bleeding profusely from a wound in the occipital region, at the bottom of which a depression could be felt. Both pupils reacted normally and there was no paresis or paralysis. His back was much bruised, but there was no irregularity of the spinous processes. His pulse was 120, regular, and temp. 97°.

At 9 p.m. the wound was examined under an anæsthetic, and was found to extend from just below the external occipital protuberance upwards and slightly outwards for about three inches; from the upper end an incision was made for about two inches, and the flap thus formed was turned outwards. It was then seen that there was a gap in the skull about three inches long and one third to two thirds inch wide; in this gap were fragments of bone and lacerated brain matter. The fragments of bone were removed by forceps and one fragment at the upper end was elevated; a linear fracture ran outwards from the upper end of the gap. The inner table was more extensively fractured. It seemed probable on seeing the injury that it was produced by the man falling with the back of his head against an edge. After well washing the wound an attempt was made to close the aperture in the dura mater, but was unsuccessful. The wound was therefore closed with gut sutures, and a large wire drain inserted.

During the night the patient was very restless, and his pulse was very irregular, at times almost imperceptible, and brandy and strychnine (twice) were given.

March 15th.—Temp. 98.6°, pulse 120 regular. No vomiting or paralysis; unable to pass his water; complaining of pains in his back; examination showed no sign of fracture; knee-jerks much exaggerated; no ankle-clonus; plantar reflex normal; no affection of sensation.

March 22nd.—The wound was dressed, and found soundly healed, and visibly pulsating; knee-jerks still excessive, but less so; still unable to pass his water, which is drawn off three times in the twenty-four hours.

April 8th.—Patient complains of dimness of vision, especially of objects to his right.

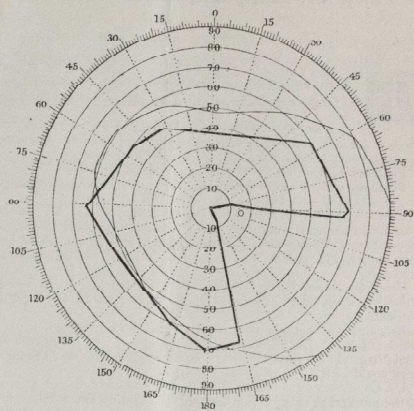
April 15th.—Getting up. Able to pass water naturally; patient feels weak, but is able to walk without feeling giddy.

April 20th.—Discharged. There is still difficulty in seeing objects placed to his right; he can read slowly, but the words appear blurred; the knee-jerks are still exaggerated, but there is no ankle-clonus; there is no difficulty of micturition, but he has not perfect control over his rectum when the motions are loose. Unfortunately I could not take his fields of vision. The patient was seen again on July 16th, when his condition was as follows:

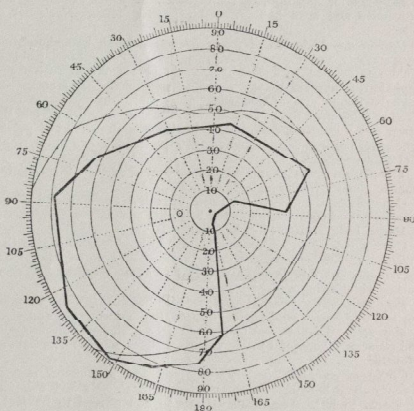
His vision was improving and he was able to read comfortably; on he was free from headache and almost entirely from giddiness; on taking his "fields of vision," it was found that there was partial

right hemianopsia, confined to the lower part of the field; the pupils reacted to light and accommodation, and both fundi and the optic discs were natural.

RIGHT



LEFT



Apart from this and weakness in his back his general condition was very good.

I have to thank Mr. Willett for permission to publish this case.

Two Cases of Transverse Presentation.

By J. A. WILLET, M.B., M.R.C.S., L.R.C.P.

THE two following cases have been admitted to Martha under Dr. Champneys during the past four months.

**CASE 1.**—F. P., 13 para, admitted Martha February 26th.

**History.**—All previous labours straightforward, last three and a half years ago; last period ended June 6th. Does not remember any accident or injury during her pregnancy.

February 14th.—Felt fetal movements for last time.  
February 15th, 2 a.m.—Waters broke; quantity excessive (filling a large pail), they were brownish in colour and offensive.  
February 19th.—Labour pains commenced, sent for her doctor who found an arm prolapsed. After consultation with two other medical men chloroform was administered and version attempted, but this failing, the patient was sent up to hospital and admitted at 8.30 p.m.

**Condition on admission.**—Patient did not appear much distressed, pulse 100, temp. 98°. Fetal heart not heard; retraction ring well marked.  
Left arm was outside vulva; the pelvis was occupied by the trunk of fetus. Left shoulder, side of chest, and the spinal column could be made out; fetus peeling and offensive. Neither head nor neck could be felt.

Dr. Champneys was informed of patient's condition, and arrived at the hospital at 11 p.m. On abdominal examination a retraction ring could be felt midway between umbilicus and pubes. Fetal heart not heard.

Left arm of fetus outside vulva. Fetus in left cephalo iliac dorso-posterior position, i.e. an L.O.P. in which shoulder had descended and head had receded into iliac fossa. Neck out of reach.

**Operation.**—Abdomen of fetus opened through hypochondrium with scissors, and ribs cut through until spinal column was reached. This was divided with bone forceps in lower dorsal region and cephalotribe applied to the lower (pelvic) end. By traction on cephalotribe, in conjunction with a crotchet which had also been fixed to same part, fetus became flexed in lower dorsal region, the lower end of the back followed by breech were drawn out of pelvis. The extended legs were brought down, the thoracic end of the trunk and after coming head were delivered as in a breech case.

The placenta was expressed after 15 mins. and an intra-uterine douche given. Fetus male 7½ lbs.  
Convalescence uneventful. Temp. on 8th day rose 103° due to a small patch of parametritis in left broad ligament.

March 11th.—Patient left hospital.  
**CASE 2.**—A. H., æt. 26, primipara, admitted Martha May 27th.

**History.**—Last period ended in the last days of August, 1900; foetal movements last felt during morning May 24th. May 23rd strained herself while lifting a weight.

May 26th.—Slight pains began, sent for her doctor who examined her and told her to send again. Waters broke during evening.  
May 27th.—Doctors sent for, who found a prolapsed pulseless cord and point of elbow-joint inside vulva. Patient sent to hospital and admitted.

**Condition on admission.**—Pains slight and infrequent, is very nervous about herself. Pulse 108, temp. 98½°. Marked obliquity of uterus to left. Arm brought outside and proved to be right. Vertex could be felt lying in the position of the pelvis. Cord prolapsed and pulseless.

Examination under anæsthetic one and a half hours later. Head was found to have receded and was lying in left iliac fossa, the brim of the pelvis being occupied by the trunk of the fetus, position of the back being anterior. (Right cephalo-iliac dorso-anterior.) Right shoulder, right side of chest, and vertebræ could be easily identified. During examination pains were frequent and strong.

Dr. Champneys was informed of patient's condition and arrived at the hospital at 5 p.m.

**Operation.**—With some difficulty sharp hook was passed over the neck which was cut through, the operation being completed with scissors.

Body of fetus easily delivered by pulling on arm. Neck was seized with craniotomy forceps, and after perforation head was pulled out through pelvis.

Child, male, 6½ lbs.; skin peeling; placenta removed by hand. Intra-uterine douche given.

At 10 p.m. Patient felt cold and temperature had risen to 104°, pulse 140. Next morning had fallen to 99°.

Convalescence rapid and temperature never above normal, except on third day when it was 100°. Patient left hospital on thirteenth day after delivery.

**Statistics.**—Guy's Hospital, 1 in 354 cases; Herman, 1 in 200 cases.

**Causes in both cases** death of fetus and perhaps hydramnios in first case.

**Other causes** are usually:  
Contracted pelvis with exaggerated uterine obliquity.  
Premature labour.  
Placenta prævia.

Cases of spontaneous delivery must naturally be few, as for this to take place the child must be small. The mode varies according as the child is alive or dead.

**If alive**, delivery takes place either by (1) spontaneous rectification, or (2) spontaneous version, or (3) rarely by spontaneous expulsion as a living child possesses muscular tone.

**If dead** it may be expelled either by spontaneous evolution, or spontaneous expulsion.

**Treatment:**  
1. Rectification } If seen early and uterus is not in state of tetanic contraction.  
2. Version }  
3. Decapitation or spondylotomy if uterus is tightly contracted round child, as the risk of rupturing the uterus or vagina is too great in attempting to deliver by the other methods.

Notes.

SIR THOMAS SMITH has been appointed Knight Commander of the Royal Victorian Order.

THE Honorary Degree of D.C.L. has been conferred upon Sir William Church by the University of Glasgow.

DR. TOOTH has been appointed a member of the Commission to inquire into the present state of the R.A.M.C., and the possibility of its reorganisation.

MR. McADAM ECCLES has been elected Hunterian Professor at the Royal College of Surgeons of England, and will deliver a series of three Lectures on the "Anatomy, Physiology, and Pathology of the Imperfectly Descended Testis" on February 24th, 25th, and 26th, 1902.

MR. WARING has been appointed Joint Lecturer on Anatomy in place of Mr. Lockwood, resigned.

DR. W. JOHNSON HORNE acted as Hon. Secretary of the Museum Committee at the Congress on Tuberculosis.

MR. T. RIMOLD SMITH has been appointed Honorary Surgeon to the Stockton and Thornaby Hospital.

THE Raymond Horton-Smith Prize for the best M.D. thesis of the year in the University of Cambridge has been awarded to Dr. W. Langdon Brown.

THE degree of M.D.(Cantab.) has been conferred on Mr. W. J. Horne, Mr. R. A. Yeld, Mr. E. W. Ormerod, and Mr. C. F. Lillie.

MESSRS. G. V. BULL, F. E. Murray, A. S. Mellor, and H. H. Riddle have taken the degrees of M.B., B.C.(Cantab.); Messrs. L. B. Scott and N. Maclaren that of B.C.

THE Wix Prize for an Essay on the Life of William Stokes has been awarded to W. A. Aldred.

THE Bentley Prize (Medical Cases) has been awarded to E. C. Williams.

THE Shuter Scholarship has been awarded to C. F. Hadfield.

THE Sports were held in a blazing sun and grilling heat on the second day of the Cricket final, which may have kept down the number of spectators; but one is getting accustomed now to a meagre attendance at this fixture. The entries and starters were, however, rather above the average, and some good finishes were seen.

WITH great pleasure we record the fact that we have once more been successful in the Inter-Hospital Athletic Competition. We were well ahead of the other competitors, and as most of our representatives will be available for some years, there is every hope that we may keep the Shield for some length of time.

THE result of the Final Tie of the Inter-hospital Cricket Cup was very disastrous from our point of view. The Guy's batting was even better than their bowling, and Barker's innings would have been worth seeing anywhere except from the field; but 54 in our second innings was not a great effort even in the face of a big score by our opponents.

THE Junior Staff XI has met and defeated the Hospital Employés Cricket Club. We hope to chronicle further news of this sporting enterprise.

A BART'S man, writing from New Zealand, has suggested that when Christ's Hospital is acquired, and when the new buildings are begun, some accommodation might be provided for Old Bart's men who want to spend a few days in Hospital. Ideas such as this we fear, though no doubt they would be appreciated by those who enjoyed their benefits, are too full of practical disadvantages to recommend themselves to the authorities.

Amalgamated Clubs.

CRICKET CLUB.

ST. BART'S v. HORNSEY.

Played at Hornsey. Resulted in a win for the home side.

SCORES:—HORNSEY.

D. A. Clark, b Pank	11	W. E. Turbeville, c Orton	
L. P. Weaver, run out	4	b Pank	2
E. S. Duval, b Page	0	J. A. Walleit, c Nicholas	
S. L. Clark, b Pank	20	b Pank	10
F. B. Swinestead, run out	71	G. Hart, not out	2
S. L. King, b Page	3	Extras	11
H. B. Lorry, c Adam, b			
Burroughes	47	Total	197
P. O. Murray, c Nicholas, b			
Burroughes	10		

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
Pank	18	2	58	4
Page	13	0	47	2
Nicholas	3	—	18	0
Adam	5	0	19	0
Burroughes	4	0	13	2
Anderson	6	0	19	0

SCORES:—ST. BART'S.

1st Innings.		2nd Innings.	
W. S. Newlor, b Clark	1	b Murray	1
L. V. Thurston, b Murray	0	b Murray	3
C. A. Anderson, b Murray	19		
H. N. Burroughes, b Murray	9	not out	48
B. Hudson, b Clark	3		
L. Orton, c Murray, b Clark	4		
H. W. Pank, c Duval, b Clark	19	c Hart, b Clark	3
C. F. Nicholas, b Clark	4	not out	18
A. H. Bostock, b Murray	1	b Murray	1
G. H. Adam, l-b-w, b Murray	9	run out	0
G. Page, not out	0	b Clark	3
Extras	4	Extras	27
Total	73	Total (6 wickets)	104

ST. BART'S v. LONDON.

The above teams met in the semi-final of the Cup Competition, the match resulting, after an exciting finish, in a win for Bart's by 43 runs. G. H. Orton and G. F. Page were chiefly responsible for the win, as when they became associated for the last wicket 22 runs were wanted. Honball also batted well for 30.

SCORES.

Table showing cricket scores for St. Bart's vs London. Columns include batsman names, runs scored, and totals for both teams (173 and 130).

BOWLING ANALYSIS.

Table showing bowling analysis for St. Bart's vs London, listing bowlers, overs, maidens, runs, and wickets.

ST. BART'S v. DUNSTABLE.

Played at Dunstable. Resulted in a win for the Hospital by 32 runs.

SCORES.—DUNSTABLE.

Table showing cricket scores for St. Bart's vs Dunstable, including 1st and 2nd innings and totals.

SCORES.—ST. BART'S.

Table showing cricket scores for St. Bart's, listing batsmen and their runs.

BOWLING ANALYSIS.

Table showing bowling analysis for St. Bart's, listing bowlers and their performance.

ST. BART'S v. HAMPSTEAD C.C.

For this match the Hospital was rather poorly represented, and suffered defeat by 160 runs, chiefly owing to some fine batting by Apsan-ul-Hak. For the Hospital Honiball batted well for 52.

SCORES.

Table showing cricket scores for St. Bart's vs Hampstead C.C., including batsmen and totals (328 and 175).

BOWLING ANALYSIS.

Table showing bowling analysis for St. Bart's vs Hampstead C.C., listing bowlers and their performance.

ST. BART'S v. GUY'S HOSPITAL.

Bart's met Guy's in the final of the Cup Competition, at Honor Oak, on July 11th and 12th. After scoring 250 the Bart's bowling was unfortunately completely collared on the first day, so that Guy's put together 475. In the second innings Bart's indulged in a collapse, and so finished off the match in very summary fashion.

SCORES.—BART'S.

Table showing cricket scores for St. Bart's vs Guy's Hospital, including 1st and 2nd innings and totals.

SCORES.—GUY'S.

Table showing cricket scores for Guy's Hospital, listing batsmen and their runs.

BOWLING ANALYSIS.

Table showing bowling analysis for St. Bart's vs Guy's, listing bowlers and their performance.

ST. BART'S ATHLETIC CLUB.

President.—Sir Dyce Duckworth, M.D. Vice-Presidents.—H. Mundy, Esq., F.R.C.S.; J. Christopherson, Esq., F.R.C.S.; Dr. H. M. Fletcher, Dr. S. F. Atkins, Dr. J. H. Drysdale. Committee.—H. E. Graham, G. M. Levick, S. F. Lister, W. M. Fletcher, J. G. Gibb, J. M. Plews. Captain.—B. N. Ash. Hon. Secretaries.—P. Gosse, D. M. Stone. Handicappers.—B. N. Ash, S. F. Lister, G. M. Levick. The Hospital Sports were held on Friday afternoon, July 17th. The attendance, as usual in all our athletic functions, was small, although a decided increase on that of last year. Perhaps the best performance was that of D. M. Stone, who put the weight 35 feet 4 inch. In the 100 yards T. Bates (holder) failed to get placed, B. Hudson being first, with H. J. Kimbell second. Time, 11 1/2 sec. G. M. Levick won the hammer with a very creditable throw of 84 feet. If he would train he ought to throw over 100 feet easily. In the quarter mile H. E. Graham won very comfortably in 5 1/2 secs., a close race for second place ensuing between H. Kimbell and J. S. Smith, the latter falling within three yards of the tape. The high jump was a surprise to nearly everyone present, as R. C. Berryman, with limit mark of 5 ins., jumped 5 ft. 1 1/2 ins., thereby beating the rest without the help of his 5 ins. In the first heat of the hurdles R. C. Berryman again distinguished himself by winning, being given 8 yds. from scratch. The next heat was won by a fresher, A. H. Hogarth, also with 8 yds. In the final Hogarth beat Berryman by inches only, T. M. Body being third. The long jump fell to A. H. Hogarth with a jump of 17 ft. 1 in. without his 1 1/2 ft. handicap. There were very few starters in the 120 handicap (prize presented by Messrs. Maw, Son and Sons), which fell to B. Hudson (5 yds.) first, and A. H. Hogarth (10 yds.) second. Time, 12 1/2 sec. In the weight the next best to D. M. Stone were T. M. Body (4 lb.) and J. Corbin (2 1/2 lb.). The half mile fell to E. E. Hayes (45 yds.), who won well in front of J. G. Gibb (10 yds.). We hope to see E. E. Hayes running for us in the cross-country next year. The Freshers' race fell to B. Hudson, with A. H. Hogarth second. Hudson led all the way, but stopped at the curve, not seeing the tape, but Hogarth stopped and so allowed him to win the race, which he quite deserved. The Junior Staff do not appear to have many "Byers," as only two faced the starter, J. A. Nixon and H. S. Ward, the former winning. Distance 220 yds. Time 26 1/2 sec. Six started in the mile (J. G. Gibb scratch), Gibb winning very comfortably, with T. M. Body second, L. Arnold third. The prizes were presented by Lady Duckworth, and Sir Dyce Duckworth spoke, pointing out how necessary it was for men to train properly before exerting themselves in the sports. The judges were Dr. J. H. Drysdale, and Mr. H. J. Waring, F.R.C.S. Mr. W. E. Miles was unfortunately prevented from attending. Jack White acted as timekeeper.

THE UNITED HOSPITAL SPORTS.

Held at the L.A.C. Ground on Wednesday, July 17th, 1901. President.—Sir William Church, Bart. Seven hospitals entered this year for the championship, viz. Guy's, St. George's, St. Bartholomew's, London, St. Mary's, St. Thomas's, and Charing Cross.

The scoring this year was done by points, first place 10, and second place 3 points. Guy's started their score by getting first and second in the 100 yds. S. Wadson and E. Morgan. Time, 10 1/4 sec. The half mile fell to Bart's, H. E. Graham winning, R. Allen (Guy's) second. The weight fell to St. Bart's, D. M. Stone putting the shot 35 ft. 9 1/4 in., R. Thompson (St. Thomas's) second. P. E. Lascelles (St. Mary's) won the high jump with a jump of 5 ft. 8 in., J. H. Thomas (London) being second with 5 ft. 7 in. The 220 yds. fell to Guy's, S. Wadson (the holder) winning easily, with T. Smith (St. George's) second. Time, 23 1/2 sec. H. E. Graham won the one mile for us very easily in 4 min. 36 1/2 sec. St. Bart's made 13 points in the hammer, W. M. Fletcher beating the United Hospital record with a throw of 110 ft., G. M. Levick being second with a throw of 82 1/2 ft., though he can throw more. Next came the quarter mile, adding 13 points to Guy's score, S. Wadson being first, after a great race with R. W. Allen, inches only separating them. Time, 5 1/2 sec. The hurdles were the great surprise of the day, as W. Gibson (London) beat W. M. Fletcher, after a neck-to-neck race, in the very creditable time of 16 1/4 secs. Next and last came the three miles, which was to decide whether we were to beat or draw with Guy's. Six started, but after two laps only J. G. Gibb and A. C. Birt (St. Thomas's, holder) were running. Gibb led the whole way, and when half a mile from home strode away from Birt, winning easily in 16 min. 7 1/2 sec. The result of the day's sports was—

Table showing results of the day's sports, listing events and winners.

RIFLE CLUB.

PRIZE MEETING.

The Rifle Club Prize Meeting was held on Wednesday, July 3rd, at Runnymede, on a glorious summer afternoon. The breezes were gently whispering through the sweet-scented limes, the dulcet tones of the frog were borne on the ear from the river lazily flowing close at hand (you were sent to report on the shooting—Ed.), and the loud squelch of the dum-dum bullet as it reached the soft clay of the butt made the martial heart beat with unwonted arrhythmia. The shooting, so far as one could understand, reached a very high standard. Several of the targets were scarcely damaged, and the markers were mercifully spared any ill-advised effort during the heat of the day. The entries were large, and the marksmanship, varied. The Waring Challenge Cup gave rise to an excellent competition, and the conditions seemed good and were eminently practical. It was won for the first year of its institution by Finigan, whose shooting throughout was consistent. He was disqualified by his other successes from taking the prize for the "quick-firing" competition, in which he made the top score. One highest possible was scored, Petrie making 35 at 600 yards in the Club competition. The other scores have not been obtained, but the list of prize winners in the various competitions is appended. Competition I.—1st stage of the Waring Cup aggregate. Conditions.—10 shots at 500 yards, prone position. 1st Prize.—No. 17 Cowhide "Tabloid" Medicine Case, presented by Messrs. Burroughs and Wellcome. 2nd Prize.—No. 7 Hypodermic Case, presented by Messrs. Burroughs and Wellcome. 1st. P. A. Dingle. 2nd. W. J. J. J. J.

Competition II.—The Club Competition.  
Conditions.—7 shots at 200, 300, and 600 yards, any military position.

1st Prize.—Opera Glasses, presented by Messrs. Curry and Paxton.

2nd Prize.—Hypodermic Case, presented by Messrs. Burroughs and Wellcome.

3rd Prize.—Presented by Mr. Howard Marsh.

1st. J. Morris.  
and. E. A. Wright.  
3rd. W. P. S. Branson.

Competition III.—The Club aggregate.

Conditions.—1st stage of the Waring Cup aggregate and the Club Competition.

1st Prize.—Beneftink Cup and Stethoscope, presented by Messrs. Down Bros.

2nd Prize.—Value 10s. 6d., presented by the Club.

1st. A. S. Petrie.  
2nd. A. C. Brown.

Competition IV.—The Waring Challenge Cup, presented by Mrs. Waring.

Conditions.—1st stage, 10 shots at 500 yards at the Club Prize Meeting; 2nd stage, 10 shots at 500 yards at the Inter-hospital Cup Shoot at Bisley.

The Waring Challenge Cup and Prize presented by Mr. Waring D. Finigan.

Competition V.

Conditions.—7 shots at 200 yards, rapid individual, in 1 minute, kneeling position.

Prize presented by Mr. Howard Marsh.  
J. A. Nixon.

Competition VI.

Conditions.—7 shots at 200 yards, any position, for members of the Teaching Staff.

Mr. Phillips.

The following are the scores of the matches held during this season. It will be seen that we have won 3 matches and lost 3.

ST. BART'S v. DULWICH AND EASTBOURNE COLLEGES.

Won by St. Bart's. May 22nd.

ST. BART'S.

	200 yds.	500 yds.	Totals.
J. Morris	20	30	50
P. A. Dingle	29	26	55
A. C. Brown	28	26	54
A. K. Armstrong	28	25	53
A. S. Petrie	26	24	50
J. C. Newman	27	23	50
R. A. Fuller	22	19	41
C. H. Fielding	10	27	37
Total	206	188	396

DULWICH COLLEGE

H. J. Dear	25	30	55
H. A. Clark	28	23	51
D. G. French	24	25	49
H. Wray	26	23	49
C. M. Rigby	31	18	49
K. S. Carpmael	22	25	47
F. A. Brock	23	20	43
H. Bartlett	23	18	41
Total	227	192	419

EASTBOURNE COLLEGE.

Lance-Corporal Dodd	29	32	61
Drummer Skewes Cox	29	26	55
Corporal Mackenzie	25	30	55
Sergeant Hales	29	17	46
Private Phillips	25	20	45
Private Kendziot	23	19	42
Private Thomas	21	20	41
Sergeant Atkins	18	20	38
Total	216	194	410

ST. BART'S v. ST. PAUL'S SCHOOL KIFLE CORPS.

May 29th. Won by St. Paul's School.

ST. BART'S.

	200 yds.	500 yds.	Totals.
W. R. Read	32	28	60
J. Morris	24	26	50
A. C. Brown	30	20	50
P. A. Dingle	29	27	56
A. S. Petrie	17	26	43
R. A. Fuller	27	13	40
N. Maclaren	23	14	37
C. H. Fielding	19	14	33
Total	212	182	398

ST. PAUL'S SCHOOL.

Sergeant Sinauer	32	28	60
Corporal Braddell	27	23	50
Lance-Corporal Evans	20	25	45
Corporal Arnold	19	30	49
Lance-Sergeant Bland	24	27	51
Private Barnett	27	20	47
Lieutenant Rowe	28	19	47
Lance-Sergeant Wink	30	8	38
Total	216	184	400

ST. BART'S v. RUGBY.

June 5th. Won by Rugby.

ST. BART'S.

	200 yds.	500 yds.	600 yds.	Totals.
J. Morris	29	25	55	
R. A. Fuller	31	23	54	
P. A. Dingle	29	22	51	
C. H. Fielding	20	20	40	
N. Maclaren	23	21	44	
A. K. Armstrong	22	17	39	
T. W. H. Burne	20	15	35	
J. E. Pratt	24	18	42	
Total	206	161	367	

RUGBY.

Private Hyde	30	24	54
Corporal Campbell	31	22	53
Bandsman Moais	27	25	52
Colour-Sergeant Barlow	25	26	51
Private Crowshaw	28	19	47
Private Lester	28	18	46
Private Ewing	23	20	43
Corporal Maton	25	16	41
Total	237	187	424

ST. BART'S v. LONDON RIFLE BRIGADE CADET CORPS.

June 12th. Won by St. Bart's.

ST. BART'S.

	200 yds.	500 yds.	600 yds.	Totals.
J. Morris	33	30	31	94
R. A. Fuller	31	29	27	87
D. Finigan	29	26	31	86
A. C. Brown	25	25	27	77
P. A. Dingle	24	25	26	75
T. W. H. Burne	25	25	14	64
Total	177	160	152	489

LONDON RIFLE BRIGADE CADET CORPS.

Sergeant-Instinct Nadand	28	28	18	74
Sergeant Clark	33	29	16	78
Colour-Sergeant Boyd	21	28	20	69
Sergeant Gilliland	26	18	23	67
Corporal Tanner	29	17	21	67
Assist. Sergt. Inst. Tuffill	19	15	16	50
Total	166	143	114	423

ST. BART'S v. HIGHGATE.

June 19th. Won by Highgate.

ST. BART'S.

	200 yds.	500 yds.	Totals.
A. S. Petrie	26	31	57
W. Jeddine	31	22	53
C. H. Fielding	24	22	46
P. A. Dingle	25	20	45
G. E. Pratt	21	21	42
T. W. H. Burne	22	20	42
Total	159	146	305

HIGHGATE.

Private R. R. Prentice	29	25	54
Sergeant Pocock	27	26	53
Private Wilcox	27	26	53
Private Hemp	27	25	52
Sergeant Hetherington	30	21	51
Corporal Sharpe	29	21	50
Total	179	165	344

ST. BART'S v. WHITGIFT GRAMMAR SCHOOL.

June 12th. Won by St. Bart's.

ST. BART'S.

J. Morris	33	30	63
R. A. Fuller	31	30	61
D. Finigan	29	26	55
A. C. Brown	25	25	50
P. A. Dingle	24	25	49
T. W. H. Burne	25	25	50
Total	178	161	339

WHITGIFT.

Lieutenant Smith	28	30	58
Sergeant Becker	28	29	57
Private Odden	30	26	56
Corporal Hodson	23	28	51
Private Edridge	21	29	50
Private Sparrow	24	23	47
Total	164	175	339

Reviews.

MODERN SURGERY, GENERAL AND OPERATIVE, by JOHN CHALMERS DACOSTA, M.D., Professor of the Principles of Surgery, Jefferson Medical College, Philadelphia. 493 illustrations, some coloured. Third edition, revised and enlarged. (London: W. B. Saunders and Company, 1900. Pp. 1117.)

This volume is the third and revised edition of a surgical handbook which is better known in America than in England.

The title of the book scarcely corresponds to its contents, since in addition to dealing with surgery, general and operative, a considerable portion of the work is devoted to "Special or Regional Surgery."

The latter portion of the subject is dealt with in a somewhat incomplete manner, and in our opinion ought either to have been left out altogether or to have been treated in more detail. The "general and operative" parts are better, but even these cannot be said to be quite "modern" and up to date.

The clinical descriptions are often defective, and do not afford sufficient assistance to the student. Thus on page 19, in connection with actinomycosis, the author says, "a tumour forms, which contains sero-pus, and after a time ruptures and discharges matter containing nodules composed of fungi," when he ought to have clearly stated that the tumour contains matter which is thick mucoid pus, with a characteristic odour, somewhat resembling dilute sulphuretted hydrogen, and small round or ovoid granules about the size of a pin's head of a bright yellow colour, or in rare cases grey or black, which on microscopical examination show the structures of the ray fungus.

When discussing "antiseptics," a distinction is drawn between an antiseptic, which is an agent which retards or prevents putrefaction; and a germicide or disinfectant, an agent given concerning different antiseptics, etc., but sufficient stress is not laid on the results of the author's own practice, or the principles which he himself recommends. Thus, on one page it is stated that "carbolic acid is a valuable germicide in the strength 1:40 to 1:20. It is certainly fatal to pure organisms, but weak solutions do not destroy spores," certainly fatal to but few bacteria, and it fails to kill most spores."

When discussing the preparations for an operation, the author recommends "if an operation is to be performed within the mouth, old snags and carious teeth should be removed." No consideration is given to the nature of the operation or the character of disease, simply the hard and fast rule given above.

The illustrations are in most instances taken from other works on surgery, thus in the operative part we find the well-known plates of Bernard and Kocher.

After carefully reading through this work we cannot conscientiously recommend it to students of Surgery, on account of the lax and incomplete manner in which some of the subjects are dealt with, and also owing to the fact that it does not teach the subject of Surgery in the "modern" manner to which we are accustomed at St. Bartholomew's.

A TEXT-BOOK OF DISEASES OF WOMEN. By H. J. GARRIGUES, A.H., M.D. (W. B. Saunders and Co., Philadelphia.)

The third edition of this work contains much that is worthy of the highest commendation expressed in a bald and unconvincing style. Its clinical teaching is conveyed in a dogmatic fashion which can only prove misleading to students and raise feelings of doubt in its trustworthiness in the minds of experienced practitioners. We quote as an example of this shortcoming the whole of Chapter VI in Part VII, which deals with the subject of Metrorrhagia in the following single terse sentence—"Metrorrhagia is a profuse uterine hemorrhage occurring at another time than the menstrual flow. Its causes, symptoms, and treatment are essentially the same as those of menorrhagia, just described, with the exception that this flow, being entirely abnormal, need not be allowed, and may therefore be treated from the beginning, unless the bleeding has a beneficial influence on some diseased condition—e.g. pelvic inflammation." Seeing that this definition of menorrhagia will include anything from placenta prævia to post-partum hemorrhage, it is clear that the shortness of the chapter proves its only merit. Throughout the book indeed the definitions are slovenly, the factor of clinical observation wanting, and dogmatic inaccuracies obtrusively insisted on.

The whole subject of extra-uterine pregnancy is dismissed in the following lucid description—"Extra-uterine pregnancy gives the signs of pregnancy. A tumour is felt either independent of the uterus or attached to it. The patient has attacks of sudden violent pelvic pain. Sometimes there is a bloody discharge from the uterus containing decidua sheds." Either the subject has no place in a work on gynecology, or it was worthy of something better than this; it was, however, a relief to find that no attempt is made to grapple with the treatment of the condition.

Dysmenorrhœa on the other hand forms an attractive subject for treatment; after a brief and lifeless description of the symptoms, giving due prominence to its common causes, viz., "an intra-uterine polypus playing the part of a ball valve," and antelexion "which especially predisposes to dysmenorrhœa,"—the whole wealth of a fertile imagination is poured out in recommending innumerable vaginal and intra-uterine applications—followed by a veritable catalogue of pessaries and dilators. The author's moderation in his prognosis strikes the reader as an ironical assumption of humility when he says that "in most cases we may promise relief, if not a cure."

By the time displacements of the uterus is reached, the reader, if he has persisted so far, is not surprised at anything he may find, but the unconscious humour of the chapter is ample repayment for the trouble involved. Anteversion is said to be due to various inflammations of different pelvic tissues or to deficient development of the vaginal portion of the uterus. After the subject of displacements has been fully discussed, it becomes obvious that the presence of the uterus inside the pelvis at all is a pathological or at least deleterious



mental abnormality. But the author may be relied on for unbounded resource in the matter of treatment as usual.

It is a relief to find that the technique of operating is somewhat more agreeably dealt with; for although many of the operations described are worse than useless, yet the operative measures, as a whole, are carefully detailed. The illustrations are profuse and well executed.

In conclusion, it is not easy to see what good purpose the book can serve; there have been medical writers whose literary attainments were high, their observations sound, and their methods worthy of imitation.

### Calendar.

Duties for August, 1901.

- Aug. 2.—Dr. Gee and Mr. Langton.  
 " 6.—Sir Dyce Duckworth and Mr. Marsh.  
 " 9.—Dr. Hensley and Mr. Butlin.  
 " 13.—Sir Lauder Brunton and Mr. Walsham.  
 " 16.—Sir William Church and Mr. Willett.  
 " 20.—Dr. Gee and Mr. Langton.  
 " 23.—Sir Dyce Duckworth and Mr. Marsh.  
 " 27.—Dr. Hensley and Mr. Butlin.  
 " 30.—Sir Lauder Brunton and Mr. Walsham.

### Examinations.

UNIVERSITY OF OXFORD.

*Materia Medica and Pharmacy*.—G. E. Barry, R. H. Sankey.  
*Anatomy and Physiology*.—E. H. White.  
*Final M.B. Examinations*.—R. H. Bremridge, T. E. C. Cole, L. J. Pictou.

UNIVERSITY OF LONDON.

*Intermediate Examination in Medicine.*

*Honours List*.—E. E. Maples, Gold Medal and First Class Honours in Anatomy, First Class Honours in *Materia Medica* and *Pharmaceutical Chemistry*, Second Class Honours in *Organic Chemistry*. K. S. Wise, Second Class Honours in *Physiology* and *Histology*, Third Class Honours in *Organic Chemistry*.

*Pass List*.—*Entire Examination.*

*First Division*.—J. G. Atkinson, S. M. Lawrence, W. C. Pickering, A. H. Pinder, H. W. Wilson.

*Second Division*.—T. Bates, H. Finzel, S. M. Hebblethwaite, C. R. Keed, E. G. D. Milsom, E. F. Travers, A. D. White.

*Excluding Physiology—First Division*.—J. M. Plews.

*Second Division*.—C. N. Davis.

*Physiology only—Second Division*.—W. C. F. Hariand, H. B. Hill, A. R. Neligan.

*Conjoint Board.*

*Anatomy and Physiology*.—F. E. Whitehead, J. E. L. A. Turnley, H. D. Scott, H. H. Rolfe, F. M. Newton, E. B. Lathbury, A. M. A. James, C. D. M. Holbrooke, W. S. Edmond, C. W. O'Brien, A. F. C. Pollard, A. D. White, A. H. Muirhead, H. M. Huggins, B. N. Ash.

### Junior Staff Appointments.

The following nominations have been to-day made for Junior Staff appointments:

HOUSE PHYSICIANS.—October 1901.

Sir William Church.	J. C. Sale.
Dr. Gee.	E. M. Niall.
Sir Dyce Duckworth.	L. J. Pictou.
Dr. Hensley.	H. Whitwell.
Sir Lauder Brunton.	A. Croft Hill.

HOUSE SURGEONS.—October, 1901. April, 1902.

Mr. Willett	- E. H. Hunt	..... R. H. R. Whitaker.
Mr. Langton	- F. E. Murray	..... A. J. Fairlie-Clarke.
Mr. Marsh	- J. D. Hartley	..... H. Walker.
Mr. Butlin	- S. R. Scott	..... J. F. Jennings.
Mr. Walsham	- A. W. Izard	..... H. B. Butler.

Intern.....	October, 1901	..... F. A. Rose.
Extern.....	October, 1901	..... W. T. Rowe.
".....	January, 1902	..... R. C. Elmslie.

### Appointments.

BEAUMONT, N. C., M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Royal Hospital, Portsmouth.

DONALDSON-SIM E., M.R.C.S., L.R.C.P., appointed House Surgeon to the Hertford Infirmary.

BULL, G. V., M.B., B.C., appointed House Surgeon to the Children's Hospital, Great Ormond Street, W.C.

SMITH, T. J. RUDOLPH, appointed Honorary Surgeon to the Stockton and Thornaby Hospital.

### New Addresses.

COLLINGS, D. W., Ryde House, Woking.

GRAHAM, Charles H., Wellington, New South Wales, Australia.

SARGANT, W. E., 1 Devonshire Villas, Bowes Park, N.

SUGDEN, D'ARCY, Buckfastleigh, Devon.

WILLIAMSON, J., Homeleigh, Heathcote Road, Epsom.

### Births.

JOY.—On July 3rd, at Bradfield, Berks, the wife of N. H. Joy, M.R.C.S., L.R.C.P., of a daughter.

SCORER.—On July 7th, at Maplestead, Old Christchurch Road, Bournemouth, the wife of Frank Scorer, of a son.

WYNDHAM.—On June 27th, at Croft Lodge, Goring-on-Thames, Winifred, wife of T. Lancelot Wyndham, L.R.C.S., L.R.C.P., of a daughter.

# St. Bartholomew's Hospital



## JOURNAL.

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### St. Bartholomew's Hospital Journal,

AUGUST, 1901.

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

### A Chinese Midwife.

By H. J. WALTON, M.B., F.R.C.S.,  
 Capt. I.M.S., 7th Rajputs, China Field Force.

**N**OW that the position, status, and responsibilities of the midwife are attracting so much attention in England, it occurred to me that it might be interesting to interview one of the sisterhood in China, and to hear her view on the subject of obstetrics. Among the "staff" of a dispensary for Chinese that I have

been "running" for the last few months in Pekin is an "ex-Boxer"; at least, the British Police Commissioner kept him in prison for five months as such, and certainly his personal appearance is somewhat against him. On his release from prison he was handed over to me as a "dresser," and has turned out a great success, being very keen and energetic. He fairly revels in gore, and it is a sight to be remembered when he is allowed to open an abscess. Catheterisation is another operation in which he takes the greatest interest, and one shudders to think of him as "Lord High Executioner" in the next Boxer rising, forcibly passing a "No. 12" through a tight stricture. "Death by the hundred cuts" would be almost merciful in comparison.

To return to the midwife. I asked my Boxer friend, whose knowledge of Pekin appears to be both "extensive and peculiar," to find out a midwife in flourishing practice, and to invite her to pay me a visit. None came for several days; all that I could get out of the Boxer, through an interpreter, was that it was "very difficult." However, one day he produced one triumphantly, and told me that she had one of the largest "family practices" in Pekin.

The midwife was a withered old dame, with rather an intelligent face. She informed me that she had been "in practice" for forty years, during which time she had attended, on an average, about a hundred confinements a month. I am afraid that I looked rather incredulous, and she appeared to be a little surprised herself when I reminded her that she must have attended forty-eight thousand cases. However, she recovered her self-possession and said, "Well, I dare say I have."

The profession appears to be an hereditary one; her sole "qualifications" for it were that her mother and grandmother had both been midwives. She assured me that I might implicitly believe all that she said, and added that "of course men-doctors could never understand the diseases and tribulations of women." She herself knew the remedies for all the "seventy-two diseases" to which women are subject, except that for "shortness of breath." The

following are some of the facts and customs that I learnt from her:

The sex of the child may be foretold at the end of the third month of pregnancy by feeling the pulse at the right wrist and in the digital arteries of the mother. A male child is also indicated by the mother's "happy expression."

During the second and third stages of labour the mother should sit up on the edge of a chair, with her legs widely open.

The umbilical cord is not to be divided until the child cries; it is not tied, and is left of such a length that the end reaches to the top of the child's head. If hæmorrhage occurs from the cut end, the cord is to be twisted between the fingers. It is then dusted with alum and wrapped up in a piece of paper.

If the third stage is not completed within a few minutes of the birth of the child, the cord must not be pulled upon; but the hand, previously washed, is to be introduced, and the placenta pulled out. My informant knew nothing about retained membranes.

The mother is to sit up for some hours after delivery, "lest the blood should mount to the head." If the child is born asphyxiated, it is to be "dandled" on the palm of one hand; this never fails to resuscitate it.

If a hand or arm presents by the side of the head, it is to be manually replaced. Prolapse of the cord "does not matter at all." In cases of disproportion between the sizes of the head and pelvis, one should do nothing "for several days." Chinese women of the upper classes take very little exercise—how can they, poor things, on their absurd little feet? and their labours are usually tedious. If, after a long delay (*i.e.* more than "several days"), the child is not born, the sides of the abdomen are to be well squeezed. If the child is dead—and this is known by the mother's pulse—the head is to be broken up with the fingers. If this is impracticable "it doesn't matter." My particular midwife never uses instruments of any sort.

If delay is due to rigidity of the soft parts of the outlet, they are to be stretched with the fingers.

In breech presentations the arms are liable to become extended by the sides of the head; they are to be drawn down by digital traction on the elbow.

If the after-coming head is delayed, once more "it doesn't matter."

As regards transverse presentations, the old lady declared that she had never met with one (among all the forty-eight thousand cases!—H. J. W.) which she had not been able to rectify by means of one hand in the vagina. She never performed podalic version for any reason whatever.

Ante-partum hæmorrhage meant that the woman had been working too hard. It was to be treated with Chinese medicine. The midwife knew the name of this medicine, which could be bought at all the native drug stores, but she did not know of what it was composed.

Placenta prævia she knew nothing about.

Post-partum hæmorrhage, if moderate, was rather beneficial than otherwise, as it ensured the blood "not getting to the head." (This latter condition appears to be the hogey of Chinese midwifery!) If more severe it was to be treated with medicine. If very severe the abdomen should be rubbed vigorously.

Foul lochia and fever, coming on a few days after confinement, should be treated with medicine, and are generally due to women not sitting up at once after confinement. The midwife ceased her attendance on the third day, and knew nothing of what happened afterwards!

Swollen legs and "fits" in connection with pregnancy should be treated with Chinese medicine, and "do not matter." Such cases are never fatal!

A child should be suckled by the mother for three or four years. This makes it very strong! But it should receive additional nourishment after the age of one year.

Twin pregnancies were very rare; the midwife had never met with a case of triplets.

The duration of pregnancy is nine lunar months and ten days.

Female infanticide, which is not illegal, is common among the poorer classes. It is performed by the parents, the favourite method being to put the luckless infant in a jar and close the lid.

The fees for confinements are not large, varying from one to five dollars.

The old lady had often inserted needles into swellings in the abdomen, letting out a great deal of "water of different colours," and invariably curing the patient.

We parted the best of friends. The midwife drank a cup of tea with me, and shook hands vigorously with herself, and I noticed that, in spite of her intimate acquaintance with the "seventy-two diseases," she procured from the officious Boxer a bottle of the "indigestion mixture" (our old friend the Bart.'s "Haust. G. nt. cum Rhco"); but then, perhaps, her own complaint was "shortness of breath."

### The History of our Special Departments.

The Mid-Sessional Address delivered before the Abernethian Society on June 26th, 1901, by J. A. ORMEROD, M.A., M.D., F.R.C.P.

**J. A. ORMEROD** said that in the history of our special departments he imagined at first that he had secured an interesting subject for the address. But when he came to look into it he found that several of these departments really had very little history to record, save that they had come into existence and still existed. Either their original conception had been so good that they were capable of no further development, or else (which was more probable) this development was to come.

There had been special departments at the hospital which had lived and died. For instance, there were special wards for infectious fevers not so long ago. The arrangement in force up to 1874 was that all cases of infectious fever,\* smallpox excepted, were taken into the general wards. At that date typhus was practically non-existent, though there had been plenty previously, and more than one sister and nurse had caught it and died. Diphtheria was not nearly so frequent as it became some years later. There was, however, plenty of scarlet fever, and the speaker well remembered his first case, which was planted in the middle of Mark Ward. However, in 1874 the Treasurer asked the Medical Council whether these infectious cases ought not to be put into separate wards. The Council replied that a separate building ought to be provided. This presumably was impossible, owing to our ever-present difficulty of space; at any rate it was not done, and in 1875 the upper floor of the west block, consisting of Radcliffe, then a general medical ward, and Lazarus, then the male syphilitic ward, was shut off, as well as could be done, from the rest of the block, and converted—Radcliffe into a scarlet fever ward, Lazarus nominally into a typhus ward, but really into a ward for typhoid, diphtheria, and doubtful cases.

The Medical Council seem to have regarded this arrangement as a temporary expedient; but the separate block was never built, so there were fever wards, not a fever building. No doubt it was an excellent idea that students should be able, within the walls of their own hospital, to study every variety of disease; and, indeed, until the Metropolitan Asylums were thrown open to them, they had little opportunity of studying fevers anywhere else; but public opinion was becoming more sensitive on the subject of isolation, and our plan of isolation was admittedly a makeshift, and so the plans had to be banished. Radcliffe was closed for scarlet fever in 1884, and, after doing duty as a diphtheria ward on a large scale in the epidemic which we had some few years later, finally settled down to its present position. The opposite ward, formerly Lazarus, was also closed for fevers, and has been at various times since—a nurses' bedroom, a temporary "cholera" ward, and an erysipelas ward under the name of Coborn.

Formerly, too, there were special wards for venereal cases—fifty beds for females in Magdalen, which covered the whole upper floor of the east block, and twenty-five for males in Lazarus at the top of the west block. Then special wards were instituted about 1853, and continued in full swing for over twenty years. But when the fever wards were instituted the male syphilitic cases were transferred to the top of the east block, thereby reducing Magdalen one half. In 1882 this male syphilitic ward was given up to erysipelas, and the one remaining venereal ward was divided into two parts, male and female; and in 1895 this class of ward was given up altogether.

Neither the fever wards nor the venereal wards were under the care of one particular physician or surgeon, and so they were not specialities in that sense. Magdalen (by some of the surgeons) used to be handed over to a dresser for the week, the house surgeon going there if he was wanted particularly, and the surgeon having one afternoon there.

Tradition says that once, on account of some imaginary grievance, a rebellion broke out among the women in Magdalen, and that they all got out of bed and out of the window, and there, behind the balustrade, defied the steward in the square beneath.

There was once a vaccination department, but it had a very short life. Originally vaccination was done by the apothecary, an official in whom many functions centred. He assisted the physicians in the wards. He did such operations as cupping, bleeding, and electrifying the in-patients, until the institution of house physicians in 1867. He also saw the surplus out-patients who remained after the distributions of Governors' letters. Then, as now, the surplus must have been considerable; for of the apothecary it was said that he would marshal his army by the words "Diarrhoea to the right, coughs to the left, all those with a pain in your stomach hold up your hands." Evidently this was the origin of our present casualty department, itself containing no special department, but the mother of them all, to whom they look for their daily bread, praying that their food may be neither scanty, nor excessive, nor yet monotonous, but occasionally enriched by some pathological plums. But to return. In 1867, the apothecary having resigned and his office having lapsed, the teaching and practice of vaccination was handed over to the two

\* It appears, however (*vide* an article by Sir William Church in the 'Hospital Reports' for 1886), that at an earlier date smallpox was admitted, and that in 1752 special wards were set apart for it.

junior assistant physicians, who were in 1868 Dr. Church and Dr. Gee, and in 1869 Dr. Gee and Dr. Duckworth (giving them their then titles). But in the following year the vaccination department disappeared, having been starved out, in the opinion of Dr. Gee, by the general practitioners of the neighbourhood. Vaccination was chiefly performed upon the babies who had been introduced to the world by the students of our extern midwifery department. But the doctors of the neighbourhood, who perhaps did not regret the loss of the midwifery, did not desire to lose touch with the mothers altogether, and as a result the hospital vaccination department died of inanition.

Of the special departments that survive and flourish, the department for midwifery and diseases of women deserved first mention. This had not always its present high rank and excellent organisation; the physician-accoucheur had, indeed, to struggle to gain for himself a proper recognition, a fact that seemed curious when we remembered that midwifery was alluded to as part of the hospital work so far back as the time of Edward III, as appeared from the quotation in our Handbook, "Mulieres prægnantes quoque de puerperio surrexerint, necnon ad omnes pueros de eisdem mulieribus genitos usque septennium si dicte mulieres intra hospitale prædictum decesserint." Perhaps the last clause, which rendered the hospital liable to support orphaned children for seven years, contributed to keep the midwifery cases out.

Lectures in midwifery existed before there was any practical teaching of the subject. Dr. Rigby was lecturer from 1838 to 1849, and in 1848 Dr. Charles West was made joint lecturer with him. In 1848, too, Dr. West was made honorary physician-accoucheur, and in that capacity took charge of uterine cases as out-patients. Next year, at his suggestion, an extern midwifery department was instituted. Four years later (1853) the uterine cases among the in-patients were put in a separate ward at the top of the south block—the beginning of Martha Ward. Thus all three branches of this department, gynaecological wards, gynaecological out-patients, and extern midwifery department, were instituted in Dr. West's time. But the physician-accoucheur found himself in an unsatisfactory position. He was an honorary officer; *i.e.* while the physicians and surgeons received 100 guineas or £100 per annum, he received nothing. In 1855 Dr. West complained to the Treasurer both of this and of the fact that he was not invited, like the rest of the staff, to the Hospital dinners and other festivals. It was resolved to give him a "gratuity," which doubtless in time developed into a regular payment. Fourteen years later his successor (Dr. Greenhalgh) complained to his colleagues that he had no seat on the Medical Council, and that he did not, like the other teachers in the School, receive any share in the School profits. Thus the head of the gynaecological department had for many years to be inferior in rank to his medical and surgical colleagues, a matter which has long since been put right. The only difference now between the physician-accoucheur and the other physicians is that the former is elected by the House Committee, not by the General Court of Governors, and this might be considered no disadvantage if a candidate who had to canvass them.

There was little to say concerning the history of the in-patient branch of this department, except, perhaps, as to the arrangement for the performance of the major operations. These had always been retained by the surgeons in their own hands. In 1860 it was arranged that each of the four surgeons should take them, month and month about. In 1870 a new arrangement was made, viz. that the junior of the four surgeons should take the work, being assisted by the senior assistant surgeon, who thus got a sort of training for his duties as junior surgeon. This arrangement appeared also to have lapsed in favour of the present one, whereby for some eight or nine years Mr. Cripps had been entrusted with the Martha operations, and with the very best results. A full description of the organisation of the Martha theatre by Mr. Cripps would be found in the 'Hospital Reports' for 1867.

The out-patient branch appeared soon to have become a heavy tax on the physician-accoucheur. In 1867 Dr. Greenhalgh asked for an assistant physician-accoucheur, and his request was refused. Having again asked for assistance in the out-patient room he was allowed a "senior midwifery assistant" (non-resident) to assist him in the wards and in the out-patient room, and to take his place during his absence. Practically he got what he wanted, for Dr. Hope, who was senior midwifery assistant, was once on duty for Dr. Greenhalgh for six months. But the actual office of assistant physician-accoucheur (as it now exists) was not made till 1875, when Dr. Godson was appointed.

About the extern (maternity) branch there had been difficulties more than once. Dr. West's original scheme for it was—

That the patients should live on the north side of the river, not more than a mile from the Hospital.

That not more than ten cases a week should be attended.

That there should be a senior pupil, to whom the pupils should apply in case of difficulty or danger.

That in emergency or serious danger the senior pupil should apply to the lecturer.

In 1867 complaints were made that students did not attend the cases allotted to them, and further rules were drawn up and suggestions made. Again, in 1872 the Treasurer made serious complaints against this branch of the department, and it was then apparently that the resident midwifery assistant\* was first recognised by the Hospital authorities, and appointed by them like the rest of the junior staff. It was regrettable that the students should have been blamed for neglect; but perhaps they had some excuse, for the mothers were notoriously unpunctual in their confinements, and the babies took a perverse delight in being born upon Sundays or other holidays. In 1878 Dr. Matthews Duncan brought the subject of the maternity department before the Medical Council, and a deputation went to the Treasurer about it. In 1891 a reorganisation of this department was made, and the immediate superintendence thereof was transferred to a new officer, the extern midwifery assistant, and he with his bevy of clerks was required to live at "Mackenzie's," so that they might be easy for the anxious messengers to find, and have luxurious apartments for themselves.

About the maternity practice there were always wild legends, as, for instance, that once in Whitecross Street, at a critical moment, the floor gave way, and the whole party went through into a fried fish shop underneath.

Names of the physicians who have presided over the Department for Midwifery and Diseases of Women:

Dr. West from 1848 to 1861, when he resigned.  
Dr. Greenhalgh from 1861 to 1877, when he resigned.  
Dr. Matthews Duncan from 1877 till his death in 1890.  
Dr. Godson, as assistant physician-accoucheur, from 1875 to 1890, when he resigned.  
Dr. Champneys, as physician-accoucheur, and Dr. Griffith, as assistant physician accoucheur,  
"whom God preserve!"

The ophthalmic department, unlike the gynaecological, seemed to have blossomed into completeness very quickly. Four special departments were started, nominally, at any rate, in 1867, viz. eyes, ears, orthopedics, and skins. The reason for this sudden rush into specialities the speaker did not certainly know. He had been told that it was because the school wanted a fillip, and that it was thought well to give the younger members of the staff, assistant physicians and surgeons, more opportunities for teaching; at any rate, the specialities were placed in their hands, and taught in out-patient practice.

The first "demonstrators of diseases of the eye," in 1867, were Mr. Callender and Mr. Langton; the next, in 1868, Mr. Langton and Mr. Vernon; and now there was advertised a special course of demonstrations with the ophthalmoscope, the first, presumably, of those invaluable demonstrations which Mr. Vernon continued for so many years. In 1869 Mr. Vernon was sole demonstrator. During this year wards were being built, our present eye wards and theatre, placed on the top of the Abernethy-Lucas block (which was already in existence); they were opened in 1870, and described by Mr. Henry Power in the 'Hospital Reports' for 1871. Mr. Power and Mr. Vernon were made surgeons; the former became lecturer, the latter continued his demonstrations, and for many years they successfully carried on the ophthalmic work of the Hospital—Mr. Power fill his resignation a few years ago, Mr. Vernon till his sad death this year. One other appointment, equally wise and successful, was made at or about this time, namely, that of the Sister of the Ward, without whom we should scarcely recognise the place. Thus within three years the eye department became fully equipped and organised; and in this organisation there were two points which the speaker thought deserved notice. First, there were two surgeons, senior and junior perhaps, but not one called surgeon and one called assistant surgeon. Secondly, there was no hard and fast line between in-patient surgeon and out-patient surgeon—all in-patients for the one, all out-patients for the other; but both had beds, and

\* His predecessor, the senior pupil of Dr. West's scheme, lived in college, but was not necessarily a qualified man nor an officer of the Hospital. But the various schemes and recommendations made about the midwifery assistants, senior and junior, are very confusing.—J. A. O.

both saw out-patients. No need to say how great a boon it is for a man engaged in seeing out-patients to have beds in which he can follow up cases that must be admitted; it might also be a good thing for the man in charge of wards to continue to see some out-patients. It would be answered, no man would do this as he gets on in life and in private practice. But Mr. Vernon did, in spite of feeble health, and in spite of the development of a fatal illness; and when first obliged to take to the bed from which he was never to rise, his anxiety was to be back teaching and working in the out-patient room.

There was no need to say that the original staff of the eye department had found worthy and capable successors in Mr. Jessop and Mr. Holmes Spicer, and every one hoped that they would spend an equally long time in its service.

As regards the rest of the brood of special departments which were hatched out in 1867, they were still struggling along, as best they could, in their original form of out-patient departments.

The aural department was taken from the time of its foundation up to 1872 by Mr. Thomas Smith, and from 1872 till 1880 by Mr. Langton; and then Mr. Cumberbatch, who had been making a special study of ear disease and doing work in the department for several years, was made aural surgeon. No beds were allotted to the aural surgeon, though his colleagues did their best to make up for this deficiency. It seems that deaf people do not captivate sympathy like the blind; and neither do they find it so easy to realise the important bearing which aural symptoms may have on general medicine. Anyhow, the head-quarters of the aural department had to remain in the surgery, a place of all others unsuited for the accurate study of hearing power.

Concerning the other two departments of the 1867 quadruplet, namely, the Orthopedics and the Skins, there was little to say beyond the names of those members of the staff who had held them, which were as follows:

(1) The Orthopedic Department.  
Mr. Willett from its beginning up to 1878.  
Mr. Marsh from 1879 to 1881.  
Mr. Walsham from 1882 to 1889.  
Mr. Bruce Clarke from 1882 to the present time.  
(2) The Skin Department.  
Dr. Andrew and Dr. Southey were demonstrators of diseases of the skin 1867 and 1868; but this was more or less nominal, since the skin diseases were then not seen separately, but in the course of the ordinary out-patient practice: the skin department as such was first under the charge of—  
Dr. Gee in 1870; and then under  
Dr. Duckworth till 1874.  
Mr. Morratt Baker, 1875 to 1881.  
Dr. Wickham Legg, 1882 to 1884.  
Mr. Cripps, 1885 to 1889.  
Dr. West, 1892 to the present time.  
Dr. Ormerod, 1899 to the present time.

The Throat Department was some years junior to the others, not having been started till 1874 or 1875. This department, now in the hands of the surgeons, and most ably conducted since 1892 by Mr. Bowlby, and for ten years before that by Mr. Butlin, was, nevertheless, originated by a physician, Dr. Brunton. He (Sir Lauder Brunton) said that it came to pass thus: he had the option of taking the skin department, but did not wish to do so. He thought, however, that there ought to be a throat department; he therefore went abroad and studied for some time under Schrötter at Vienna, and on his return started our throat department, which he worked for some five or six years. He still looked with affection on the old elevating chair which he had had made for the department on the Vienna model.

The provision of wards or of beds for these special departments seemed hopeless at the present time, though it was obviously most desirable. Nay, even as out-patient departments they existed under difficulties. They had no proper rooms of their own, but had to thrust themselves into the surgery or out-patient room when unoccupied, and to be cleared out again in time for the incoming physician or surgeon. Where was the demonstrator of orthopedic surgery to keep his elaborate apparatus for demonstration? Where was the bath-room for patients with skin diseases? There was, indeed, a bath, the one used by the resident medical officers; should they race the skin patients for it in the morning? Occupet extremum scabies!

Every one recognised the good work done by dental surgeons; and every one would admit that few branches of work could be more

trying than hospital dentistry. The speaker had been unable to find out for certain who was the first dentist to the Hospital, but it appears that in 1837 Mr. Arnold Rogers was appointed dentist; he subsequently became an influential governor. In 1849 Mr. Rogers became consulting dentist and Mr. Tracy was appointed dentist, and he also subsequently became a governor. In 1861 Mr. Coleman succeeded Mr. Tracy as dentist; he had previously been made lecturer on dental surgery, a lectureship which appears to have lapsed with his resignation in 1884. Demonstrations in dentistry are now held instead. Mr. Coleman, too, after resigning office, became a governor, and also Almoner.

In 1880 the dental staff was increased by the appointment of two assistant dental surgeons, viz. Mr. Lyons and Mr. Ewbank. In 1884, Mr. Coleman having resigned, a further increase was made; and two dental surgeons were appointed, Mr. Ewbank and Mr. Paterson, and two assistant dental surgeons, Mr. Ackery and Mr. Mackrell.

In 1888 (Mr. Ewbank having resigned) the staff became—surgeons, Mr. Paterson and Mr. Mackrell; assistant surgeons, Mr. Ackery and Mr. Read.

In 1891 (owing to the death of Mr. Mackrell) it became—surgeons, Mr. Paterson and Mr. Ackery; assistant surgeons, Mr. Read and Mr. Ackland.

Time failed to speak adequately of the special department which was in many ways the most interesting of all, namely, the electrical department. The electrical room of a large hospital came into touch with many branches of the hospital work—medical, surgical, and special; so that when the first officer to our electrical room, Dr. Stevenson, was appointed, that which he found most serviceable to him was the fact that, by many years of work as house surgeon and house physician, he had acquired a very wide and very practical knowledge. Moreover, in an electrical room there could always be found a certain number of cast-off cases, misfits in diagnosis and therapeutics; so that to those who are fond of curiosities it was an excellent place wherein to rummage.

In an article by Sir William Church on our apothecary's shop, in the 'Hospital Reports' for 1886, would be found quotations of some early records of electrical apparatus. Thus in 1777 an electrical machine was purchased, and in 1839, the electrical machine being like many modern ones, out of working order, a new one was made and committed to the care of the apothecary who had to use it. This was a plate machine for administering static electricity; for it was in that form that electricity was first used in London hospitals, as might be seen from articles in 'Guy's Hospital Reports,' by Addison, 1837, and by Gull, 1852.

In 1843 a bequest of £200 consols to the Electrical Institute in Bunhill Row was made over to the Hospital, though it did not appear whether any electrical apparatus was bought with it.

When the apothecary's office was abolished in 1867, the electrifying of in-patients was entrusted to the house physicians, and the electrifying of out-patients to the curator of the surgery. This functionary had (about 1858) quite a little clinique of paralysed patients, to whom he doled out, impartially and in ignorance of their diseases, faradism from the formidable coil which was used on Saturday nights for rousing drunken cases.

But in 1882 a real electrical department was made, the then in-quest room being appropriated and converted for the purpose; for space for new buildings there was none. Dr. Stevenson was put in charge, and in an article in the 'Hospital Reports' (1882) he described the room, which was structurally much as now, and in this and in a subsequent article (1886) he gave an account of the electrical practice. He thought that electricity had proved of the most service in sciatica, chronic rheumatic arthritis, and stricture of the urethra. In a late article (1888) he gave an account of many cases of uterine fibroids which had been treated by Apostoli's method of electrolysis. The diseases treated by him were therefore terribly various, and by no means limited to chronic affections of the nervous system.

Dr. Stevenson died in 1891, and Dr. Lewis Jones succeeded him. In 1892, as mentioned in an article by him in the 'Hospital Reports' of that date, some changes had been made in the apparatus. The Carré machine for the production of static electricity had been replaced by a Wimshurst machine—a much more reliable type of instrument; and bichromate cells had been altogether given up in favour of Leclanché's. There was as yet no supply from the mains.

As to the kind of cases treated, the electrolysis of urethral strictures and of uterine fibroids had been quite given up; but a very large number of naevi were being treated; and tinnitus aurium and enuresis were being dealt with successfully. There were the

usual number of nervous diseases sent both for diagnosis and treatment.

By 1897 (to quote a second article by Dr. Lewis Jones) two further changes had occurred.

(1) The current from the mains had been brought into the department. Up to the present only an alternating current was available, and if a constant current from the same source was wanted it had to be provided by making the alternating drive a motor, which, again, drove a constant current dynamo. Still the alternating current was most useful for electrical baths, of which an enormous number, both general and local, were given.

(2) The X rays had been introduced, rather to the perturbation of the other work, for out of 612 cases coming to the department no less than 217 came to be examined by the X rays, and had it not been for the timely invention of the screen, by which the picture could be directly seen, the electrical room might have been turned into a photographer's shop. Even so Dr. Lewis Jones could not well have coped with the amount of this work, but that he was able to depute a large part of it to his tried assistant, Dr. Hugh Walsham, whose skill and zeal in X-ray work were known both in the Hospital and outside of it.

Still more recently the X-ray treatment of lupus had brought further work, and thus the department was threatened with an invasion of skin disease. It had also been suggested that apparatus for the electric light treatment of lupus should be erected, but there seemed to be absolutely no place to put it in. Other methods of physical therapeutics were now much heard of, and these would find a natural home in the electrical department. But how could anything more get into the old inquest room? The cry here and through the whole Hospital was for more space—better accommodation. When Naboth's vineyard was actually in the market the sin lay in not taking it.

### A Civilian War Hospital.\*

THE report of this, the first voluntary hospital attached to a British army at the front, describes in most entertaining form the work of the Portland Hospital in South Africa, dealing in order with the equipment and interior economy of such organisations, the medical and surgical work, and in a series of appendices with various details of management.

The first section deals only with the personnel, equipment, and interior economy of the Portland Hospital, and is contributed by Surgeon-Colonel Kilkelly, Grenadier Guards, who acted as principal medical officer of the hospital. This chapter serves as a preface and a reminder; it points out the objects which must be aimed at in fitting out a war hospital—firstly, mobility, and secondly, utility; since even for a "general hospital," such as this was, mobility is an indispensable feature. The book as a whole will be a useful guide in the future, and is interesting at the present time as illustrating how unexpected in this war was the character of the medical and surgical work.

The Portland Hospital in its complete state consisted of 130 beds for N.C.O.s and men and 30 for officers. The professional staff was entrusted with the selection of the equipment which concerned their own departments, the

\* 'A Civilian War Hospital,' being an Account of the Portland Hospital, and of Experience of Wounds and Sickness in South Africa,' by the Professional Staff. (London: John Murray, 1901. Price 12s. Pp. 343.)

surgeons and physicians being responsible for their instruments, drugs, etc., while the Hon. Secretary and Surgeon-Major in military charge purchased the bulk of the equipment.

The *personnel* was carefully chosen, mainly from the St. John's Ambulance Brigade, with two R.A.M.C. non-commissioned officers, the leading idea being to make every man useful in some other capacity as well as "orderly;" so that cooks, carpenters, farriers, fitters, and clerks were all represented and ready to make themselves useful in case of need.

The old story of bad boots crops up in this chapter, but here it was due to the men themselves, who had been largely allowed to suit their own tastes in foot-gear. It throws a light on the innumerable details which have to be considered when one reads that "mess tins of military pattern were accidentally omitted from the original list of kits, but were obtained later and found most useful."

The arrangement of "hours on duty" was something in the nature of an experiment, but proved most successful, allowing as it did for a constant interchange between day and night duty.

The vexed question of tents does not seem to be settled yet; there are two or three shapes which hold the field against all rivals, but their relative merits seem to be evenly balanced.

On the whole, the opinion seems to have been that the Tortoise Tent, measuring twenty-four feet by twenty feet, divisible for carriage into four portions, was the best suited to the conditions in South Africa. These hold eight beds easily, and will take ten without crowding. In shape they are oblong, like the "European Private" tent, or "E.P.," which are slightly smaller—twenty feet by twenty feet—and accommodate six or eight beds; they have an advantage over the "Tortoise" in being made of three layers of canvas, the middle layer being red, which keeps them cooler in tropical climates. These two patterns seem to have given much more general satisfaction than the so-called "Hospital Marquees," which are heavy, indivisible for transport, and readily wrecked by the wind.

The suggestions as regards packing of stores are valuable not only for active service, but as hints to the peaceful traveller.

In the second chapter Mr. Bowlby contributes a brief summary of the career and work of the Portland Hospital, which left England on December 13th, 1899, reaching Durban on the 30th, and continued working until the end of July, 1900. The outward voyage was enlivened by such diversions as inoculation with typhoid toxin, the results of which are dealt with at length in the report on the medical side.

The first camp was pitched at Rondebosch, where the Hospital remained during January, February, and March, and apparently it would have been difficult to start

under better auspices, for the proximity of No. 3 General Hospital and the two Wynberg hospitals gave the staff exceptional opportunities of studying methods and profiting by the experience of others. During this period 477 patients were admitted, and of these only one wounded man died.

The contrast between this and previous wars is vividly brought out when one reads of a private yacht being put at the disposal of the Portland Hospital as a convalescent home.

Rondebosch was left on April 8th, and a move up country to Bloemfontein was made, and it was here that the excellent organisation was perhaps most severely tested, since for some weeks after arrival it was impossible to get medical stores sent up; however, the supply seems to have been sufficient to stand the strain even of those early days in Bloemfontein, when the condition of the hospitals was so adversely criticised by "self-constituted experts." This was the time of the Modder River epidemic of enteric fever, and the hospital was called upon to face the difficulties immediately upon its arrival; the circumstances were most unfavourable, for apart from any question of shortage of medical requisites the army had just gone through a most trying time, with long marches, short rations, great heat, and heavy rains; while to make matters worse the men's clothes and boots were worn to shreds and no tents were available. From such an army as this (elated perhaps by success, which is, however, but a poor prophylactic against typhoid and dysentery) the Hospital admitted in one day forty-two cases. Probably at Bart's a dozen medical cases in a day is about a record admission, but what does the overworked house physician say to forty-two, representing as it did a quarter of the total number of beds? these cases, too, not merely coming from the comparative discomfort of a slum, but drafted from one hospital to another in ox-waggons, with springs or without, over roads called so by courtesy, through spruits or watercourses; broken bones, dysentery, and enteric all in one glorious jumble!

The work of the Red Cross Society is alluded to in terms of the deepest gratitude—this Society seemed to have foreseen every possible contingency, and not only were its funds inexhaustible, but stranger still, its stores possessed the same quality; how these things are managed is not explained, one can only hazard the surmise that the Society contrives always to have the right man in the right place.

By July, 1900, the typhoid epidemic had almost completely died out; the hospital found itself with empty beds and empty tents—nothing to do but look after convalescents—and as the authorised time had already expired, the work was reluctantly wound up.

The section on the Medical Work is written by Dr. Tooth and Mr. Calverley; the bulk of it is devoted to enteric fever, but diarrhoea, dysentery, and sunstroke, with

other diseases due to exposure, are also considered at some length.

In no previous war has the health of the troops been so scientifically studied, and the observations on enteric fever form a valuable addition to the literature of the subject. The death rate was surprisingly low, being only 12.5 per cent. (232 cases were treated); in our own Hospital the death rate for 1900 was 10.75 per cent., and in 1899 14 per cent. How this result was obtained it is not easy to see; certain factors may have contributed—the physique of the men, coming, as they do, from a selected class, inoculation, and the rarity of pulmonary complications. It is possible, too, that of the severer and fatal cases a considerable percentage did not live long enough to be drafted to the hospital.

The question of inoculation is not greatly elucidated; the number of cases dealt with was but small, and for a scientific verdict on the subject a very much wider survey is necessary.

So far as it went the general impression seems to have been favourable to inoculation—the mortality among inoculated cases was 7.4 per cent. as against 14 per cent. among the uninoculated, and it is stated that the disease was milder as regards symptoms and duration after inoculation.

The course of the disease was, in the main, similar to that with which we are familiar in England; the onset, however, was at times complicated by the occurrence of sunstroke during the prodromal stage, causing not only an apparently sudden invasion, but also an unusually high temperature from the beginning. The eruption was at times very profuse, but in this connection the writer's meaning is not quite obvious, for he says, "In spite of assertions to the contrary we found the characteristic eruption in half our cases." Whether he refers to assertions made in relation to the South African epidemic, or to the disease in general, is not made very plain; surely Murchison (whose description seems to include the clinical varieties even of this campaign) places the percentage of cases with "rose spots" even higher than 50 per cent.

The value of the pulse is insisted on, and by no means unreasonably; whether at home or abroad no statement will be more readily accepted than this: "A rapid pulse always gave rise to grave apprehension, and was often a warning of complications."

The remarks on malignant cases are full of interest, and the exceptional virulence of the disease elicited the suggestion that some mixed infection, perhaps of the nature of a septicæmia, was at work.

Five cases of perforation occurred, and the conclusion arrived at was that the pulse is the surest guide in the diagnosis of this complication.

One hails with delight the remarks on the absence of liver dulness as a sign in these cases; some day this

fallacy will be securely confined up, and another nail is always welcome.

The dieting of enteric cases was a real but not an unsurmountable difficulty. Necessity compelled a more liberal dietary in the early stages than has hitherto been considered admissible; perhaps it will be possible in future to adopt bolder methods when there are evidences of sound digestive powers. For want of fresh milk, bread and milk, rice pudding, and even thin bread and butter were added to the condensed milk quite early in the disease without ill effect; but as the result possibly of the comparatively non-nutritious diet, alcohol was not tolerated as well as it is under the conditions in our London hospitals.

The discussion on treatment bears out our own experience here at home, and is mainly a vindication of methods that are already time-honoured.

"Simple continued fever" is once again shown up as several old friends and unrecognised acquaintances under various disguises.

Of diarrhoea, dysentery, sunstroke, and other diseases due to exposure there is but little new said, save that in South African dysentery there is but slight tendency to secondary involvement of the liver.

It is in the account of the Surgical Work, for which Mr. Rowley and Mr. Cuthbert Wallace are responsible, that one finds most that is new; with new weapons new results were expected, but probably few looked for such a complete revolution in military surgery; the experience of surgeons seems to be summarised as "least done, soonest mended." With the advances in asepsis which have been made since the last European war, one might have suggested that surgical interference would have been more rather than less common, but the consensus of opinion seems to have been in favour of leaving wounds alone as far as possible. Retained bullets had their lodging respected unless their presence were very clearly prejudicial to the health of their unwilling host.

Sepsis was remarkably uncommon, but whether as the result of climate, or the first dressing with which every soldier is provided, is a debatable point.

Injuries to bones remain the least altered by the new small-bore and high velocity weapons. Despite statements to the contrary, the experience of the surgeons in the Portland Hospital was that clean perforations are rare, and splintering or fissuring the rule, causing bony lesions, perhaps the most troublesome to treat. The value of the X rays is amply testified to in the section dealing with bones, though their sphere of usefulness was by no means confined to such injuries.

Amputations were much less frequently necessary, and conservative surgery was far more the rule than in any previous war; in fact, the one criticism the surgeons passed on the hospital's equipment was that there were too many amputation knives. Perforating wounds of joints were

attended by marvellously favourable results; not only was suppuration unusual, but in many cases the movement in the joints was scarcely affected.

Passing to wounds of blood-vessels one finds, again, that theory and surmise give way before the hard facts of practice. It had been held that the risk of perforation of vessels and subsequent hæmorrhage would be greater with the new bullets. Whether the vessels were perforated or pushed aside it was in many cases difficult to say, since the patient often recovered after apparent perforation of important vessels, and left the question still unsolved. This is the chapter which reads the most romantically; if it were not for the exceptional weight of evidence it would be difficult to credit the possibility of some of the cases.

Following on this region come the injuries to head and neck, and once again extraordinary results were met with. The worst injuries to the brain seem to have accompanied "gutter fractures," owing to the laceration of the brain-substance. Symptoms, again, were more marked in injuries to the base than in those nearer the vertex.

Injuries of the spine seem, when caused by bullets, to be no less puzzling in their complexity than when brought about by more homely means.

The chapter on nerves, with illustrative cases, is one of the best in the book, though the results of some of the injuries baffle any attempt at explanation. Undue haste to operate in nerve cases is severely condemned, and the rules for exploring are excellently expressed.

Abdominal wounds are left to the last, and are treated of in a fashion which shows that at the front the interest which this class of case aroused was no less marked than in a general hospital at home. The field for discussion was immense; no two surgeons' experiences appear to have tallied. The summary of the Portland Hospital cases seems to lie in the opening words of the chapter:—"The great advances made during recent years in the surgery of the abdomen, and the increasing safety of operations on the intestine itself, seemed to promise that bullet wounds of the abdomen might well be successfully treated by laparotomy, and that intestinal suture might save many lives. It is all the more disappointing to have to record that operations on the abdomen have saved but few men, and that, with rare exceptions, intestinal suture has been unsuccessful."

The difficulty of deciding whether the bowel was perforated by a bullet whose aperture of entrance and exit appeared to settle the matter beyond doubt led the surgeons to adopt a somewhat expectant line of treatment, with the result that the inquiry, "What proportion of patients with wounded intestine recover?" remains unanswered, since experience showed that perforating abdominal wounds without definite symptoms of injury to the gut were best left to nature.

The chance of the intestine being involved seems to

depend very definitely on the direction of the wound. Oblique and transverse penetrating wounds were more often fatal than those whose direction was horizontal and antero-posterior.

It is said that the figures relating to recovery from abdominal wounds are fallacious, since death very frequently follows too rapidly to allow the man to be removed to hospital at all.

Of all the viscera the spleen demands the greatest respect; recoveries are recorded after wounds of the other organs, but in the case of the spleen the termination was almost invariably unfavourable.

The prognosis in abdominal wounds is thus concisely stated:

1. Antero-posterior wounds are less dangerous than are oblique and transverse wounds.
2. Wounds above the level of the umbilicus are less dangerous than those below that level.
3. Wounds in the lumbar region are less dangerous than those nearer the centre of the abdomen.
4. Wounds in the splenic area are usually dangerous from loss of blood, and wounds of the liver are not nearly so likely to cause severe bleeding.
5. When a bullet is retained, and its direction is unknown, prognosis is valueless.

In two conditions laparotomy is strongly urged: first, when there is reason to suppose hæmorrhage is actually taking place within the peritoneal cavity, and secondly, for closure of wounded intestine—and no one will venture to disagree with such rules,—but in all other cases the greatest caution, almost amounting to hesitation, is inculcated.

The section on the abdominal region closes with an interesting and instructive case of rupture of intestine by contusion without penetration of the skin, which has been reported by Mr. Watson Cheyne.

Miscellaneous cases, peculiar neither to active service nor South Africa, are relegated to the last chapter, and here the method given of treating malingerers is as practical as it is simple:—"We did not think it worth while sending a suspected case back to the front, and considered that the better course was to recommend such cases for duties at the base, where medical aid would be at hand if more definite symptoms occurred."

The summary of cases treated was as follows: 1009 officers and men admitted; of these 37 died, 159 returned to duty, 303 were discharged to convalescent camps or hospitals, 98 went to England, and 412 were transferred to other hospitals at the base. Of surgical cases 303 were admitted, with 3 deaths.

For the book as a whole there can be little but praise. It is written, of course, mainly for medical readers, and to them the style will certainly prove most attractive; the facts observed are set down in readable fashion; figures and statistics are present, but they are not obtruded; there is no eagerness to display a phenomenal record of cases, nor to take credit for extraordinary results.

If we had to sum up the surgical lessons, as taught by

the experience of the Portland Hospital, we should say that asepsis has obviated the necessity for operating rather than improved its results.

The volume is excellently got up, and the illustrations, which are almost without exception from photographs or skiagrams, are worthy of the highest commendation. There are two pictures of Sanna's Post which are conspicuous for their merit.

The value of the book lies to no small extent in the fact that the observations were made by the authors with accurate and scientific discrimination; they went to the war without theories to prove, and have given to the public useful information to assimilate and an entertaining story to read, rather than any bolstered-up theories to controvert.

### Some Cases of Polydactylism and Syndactylism occurring in one Family.

By S. B. ATKINSON, M.A., LL.B.



UPERNUMERARY and webbed fingers are not very uncommon. Among classical cases are the following:—Goliath's youngest brother had six digits on each extremity (2 Sam. xxi, 20). Pliny mentions two sisters who were hexadactyl. The "Anne Boleyn sleeve" is a fashion set by that queen, who on her right hand had a supernumerary

W. S. D.—æet. 59, has a web extending for half an inch up the second interdigital cleft of each hand, this being the common situation. He knows of no ancestors, collaterals, nor descendants of such who are abnormal. He has had eleven children, of whom six were malformed as follows:

W. F. D.—æet. 28. All the five usual digits of each hand are webbed *usque ad unguis*. Projecting from the middle of the ulnar side of the proximal phalanx of each little finger is a rudimentary digit incapable of motion and attached by a cutaneous pedicle; it carries a nail, and has within it apparently a central mass of cartilage. The palmar surface of the hands present a continuous sheet of skin, with no cleft between the digits; deep transverse grooves correspond with the phalangeal joints. The feet have each six digits; the outer four on each foot are webbed; the innermost of the five metatarsal carries two free "halluces," which are larger on the right side.

He states that his mother when seven or eight months gravid with him unwittingly picked up a tortoise, this act giving her a great fright!

W. F. D.—, jun., born in Martha ward, 13th June, 1901, presents the following peculiarities:—Right hand: hexadactyl, third and fourth

digits webbed; a supernumerary little finger is present. Left hand: hexadactyl, second, third, and fourth webbed; the thumb is a wide mass with a double nail; the extra little finger is present. A photograph was taken; the skiagram was not satisfactory. The feet were bilaterally symmetrical, six toed, the inner three webbed. A skiagram showed five metatarsals.

E. D.—, æet. 26, and her three children are quite normal.  
F. D.— (died æt. 3 months) resembled her brother, W. F. D.—, sen.

A. D.—, æet. 23, has been operated upon. Is said to have had broad thumbs and supernumerary little digits, but no webbing. She was in Faith ward in March, 1901, when a skiagram showed she had five metatarsals for her six toes on each foot.

T. D.— (died in Darke ward, November, 1899, æt. 20). Twenty-four digits; no webbing.

J. D.—, 19, A. D.—, 14, males; and S. D.—, 17, R. D.—, 12, females, normal.

C. D.—, æet. 10, hexadactyl, with extra little fingers. It is not webbed.

R. D.—, æet. 6, similar to C. D.—, but with some webbing.

little finger. T. Bartholin relates a case with six, seven, nine, eight digits on the right and left hand and foot respectively. Savard quotes a case with ten digits on each extremity. Forster's case had nine; Voigt's cases thirteen and twelve; Annandale's case six fingers and two thumbs on each hand. Colburn the calculator was a member of a family which is of interest from the fact that his grandmother was polydactyl, and her deformity was still represented in four out of the eight descendants of the fourth generation.

The following family history was traced relative to a Martha-baby:

### A Case of Rapidly Growing Tumour of the Orbit.

By L. EDGAR WHITAKER, M.R.C.S., L.R.C.P.

**T**HE following case is, I think, an interesting one, as showing the very rapid rate of growth of a tumour in the orbit, presumably sarcoma, in a child.

S. K., *æt.* 4 years 5 months, male. In March last, five months ago, the mother first noticed that the child's right eye was slightly more prominent than the other, but thought that it was due to the strain of whooping-cough, from which he was then suffering. The whooping-cough got well, but the prominence of the eye became steadily worse, and on the 15th June she brought the child up to the Hospital, where he was placed under an anæsthetic and the orbit examined. There was at this time a very slight prominence of the right temporal region, but nothing definite could



be felt in the orbit, and it was thought to be a case of post-orbital hæmorrhage.

Since that time the mother has taken the child to several other hospitals, including Moorfields, Southwark-Eye, Central Eye, and the London Hospital. In the latter institution he was an in-patient nine days, but at no place was an operation advised. She now on 7th August brings him back with enormously increased proptosis of the right eye and an excessive amount in the left eye, together with great lateral enlargement of both temporal regions. His condition is as follows:

**Present condition.**—Sallow anæmic-looking child; muscles not greatly wasted, but generally poorly covered; chest poorly covered, but breath- and heart-sounds are natural; there are no enlarged glands to be felt anywhere; urine natural.

**Present health.**—Good health until whooping-cough five months ago. About one year ago "passed blood in his water," which soon passed off.

**Family history.**—Father and mother and two sisters alive and well.

**Locally.**—The temporal regions of both sides are enormously enlarged laterally, that of the right side being slightly greater than the left. There is marked proptosis of both eyes, but that of the right eye far the greatest in amount.

**Right eye.**—The upper eyelid is of a purple-red colour, with distended veins passing over it. The lower eyelid shows marked ectropion, with a mass of red œdematous conjunctiva bulging for-

ward above it, in the centre of which is a large superficial ulcer, while from the whole surface exudes a yellow muco-purulent discharge. When closed the upper eyelid does not meet the lower one. Rest of conjunctiva injected. Cornea.—At lower margin is a large circular ulcer directly continuous with the loss of surface on the lower conjunctiva. Anterior chamber and iris natural. Pupils react well to reflexes. Fundus natural; no difference in refraction or detachment pointing to an invasion of growth is seen anywhere; tension normal. All round the eyeball a slightly soft nodular mass can be felt, most plainly at outer canthus. The bony outer edge of orbit can be made out, and the skin over the swelling in temporal region is freely moveable.

**Left eye.**—The proptosis is excessive, but not so marked as in the right eye; there is no chemosis or ectropion, and the lids can be closed. A similar but slightly smaller mass can be felt round the eyeball. Fundus natural and tension normal.

**Movements.**—Those of right eye less free than those of left, especially externally, but there is no definite strabismus in either eye. Both eyes are in a state of involuntary movement.

**Vision** difficult to estimate, but he seems to see well with both eyes, recognising people at the other end of the ward.

The interest of the case lies in the fact that seven weeks ago, when first seen, there was only moderate proptosis of one eye and a slight prominence of the temporal region of that side, but in that short time both eyes have become enormously proptosed, and both temporal regions greatly swelled out by some very rapidly growing tumour.

The diagnosis made at the first examination, of post-orbital hæmorrhage, was suggested by the fact that there was then in the Ophthalmic ward a case of a boy of similar age with a similar amount of proptosis of the right eye, and which was known to be due to a hæmorrhage both from the history and from the fact that it had been under observation for a very long time.

The tension of both eyes in this case is natural, tending to show, with the vision and the ophthalmoscopic examination, that there is no direct invasion by growth of either eyeball at present. Such a tumour is rare, but the literature would seem to show that



direct entrance of a post-orbital growth into the eyeball is not common except in the very late stages, it rather tending to extend backwards and outwards towards the temporal region. The most rapidly growing tumours of the orbit are small-celled and melanotic sarcomata. There is no evidence to show that this is of the melanotic type, so that the diagnosis must remain with small-celled sarcomata, starting either from the fatty tissue at back of orbit or from the periosteum in that region.

It was impossible to keep the child under observation, as the mother took him away without even allowing an examination under an anæsthetic.

I am very much indebted to Mr. Holmes Spicer for permission to publish the case, and I have to thank Mr. P. G. Harvey for the photographs which so excellently illustrate it.

### A Case of Tinea Versicolor affecting only the Lower Extremities.

By ELDON PRATT, M.D. Lond.

**T**INEA VERSICOLOR is so comparatively common a disease that a case of it hardly warrants publication, except for the fact that all text-books and teachers say that it never occurs on the limbs except when it is also to be found extensively on the body. The following case must therefore prove an exception.

A student, aged twenty-one, consulted me last June for a patchy eruption affecting both lower limbs. He had first noticed it about Christmas, 1900, as a single patch the size of a penny on the right calf. This patch, at first thought to be a bruise, began to spread, and other spots appeared on both limbs. The spots were yellowish at first, getting a deeper brown with time. Patient had no discomfort beyond slight itching, and was subject to perspire freely.

When I first saw him I very carefully examined the whole of the body, but there was not a trace of the disease beyond the lower limbs, and then chiefly the legs, the thighs having only a few spots. The spots varied considerably in size, from that of a split-pea to a crown-piece; over the outer surface of the right calf, and evidently where the disease had first started, was a large patch the size of one's palm, the centre of which was inflamed with superficial but slight scabiness, the periphery being of the usual brownish colour. The patient was wearing no pants.

The diagnosis was easily confirmed on seeing the *microsporon furfur* under the microscope. Further, the disease readily gave way to treatment with a lotion of hyposulphite of soda, following the usual preliminary routine of hot water and soft soap, and the necessary attention to change of garments.

### Clinical Puzzles.

By JAMES L. MAXWELL, M.D.

**A**MONG the many things that one misses out here, not the least is the opportunity of an occasional visit to the old hospital, where with the help of one's old teachers one may solve the puzzles that occasionally of necessity come across the path of us at least who are younger.

Here, with a hospital of 100 to 150 in-patients, not to mention a considerable out-patient practice, it is hardly surprising that puzzling cases every now and then occur. I am therefore recording the following two cases, not so much on their own account, though I venture to think they are quite sufficiently interesting to warrant that, but in the sincere hope that someone with a better knowledge of the subjects than I possess will do me the kindness of clearing up the cases, or at least suggesting the proper explanations for them.

A—, a Chinawoman, *æt.* 23, was delivered of a male child at full term on June 15th, early morning. Patient was attended by a qualified English midwife, well versed and very careful in the necessary antiseptic precautions. The woman was a primipara, healthy in appearance, but was stated to have suffered occasionally throughout her pregnancy from attacks of gastric pain, attributed to round-worms, a few of which she had passed. At the time of her confinement she was suffering from slight præxia—very common here where malaria is ubiquitous. Assuming this to be the cause of her fever quinine was given, which however had not the desired effect of

lowering the temperature. The actual obstetric part of the case may be dismissed in a few words; the confinement appeared in every way perfectly normal, fairly easy, no instruments being used, hæmorrhage very slight, and for the few days that she lived after her confinement everything from the purely obstetrical point of view appearing all that could be wished. I saw the case for the first time on the second day, June 17th, and the condition then was as follows:

Healthy looking young woman suffering from slight pyrexia, complaining of slight uneasiness in the lower part of the chest, but principally of a tight feeling about her tongue, which she stated she was unable to protrude; this, however, was easily proved to be by no means altogether true, as she could protrude it at least fairly well. Chest and abdomen appeared perfectly healthy on examination, except for the remarkable rapidity of the pulse—130 to 140, and not quite regular; respirations were 30 to the minute; patient was also suffering from retention of urine, a point a little surprising after so easy a labour. I gave her a medicine the principal constituent of which was tinct. digitalis in *ix* doses, four times a day. She also continued the quinine she was taking. Swallowing, I may say, was quite easy. The next day, June 18th, I am sorry to say I did not see her; I had a message in the morning to say that she was much better, and though not so well in the evening, she was not sufficiently bad for me to be sent for. As she still complained of the uneasiness in the stomach region, and had the previous history of worms, she had a dose of sanoline given her, which acted fairly well, bringing away several round-worms. This was the first occasion of her bowels being opened, and the motion was passed unher. At 5 a.m. the following morning, June 19th, I was sent for, as she was said to be dying. Her condition on my arrival was as follows:—

Extremities quite cold and pulseless, heart impulse very difficult to feel, very rapid and quite uncountable, breathing very rapid and laboured, but no cyanosis; in fact, the facies did not at all resemble that of a dying person. Very marked tetany; spasms commenced with the unfolding of the thumb, then of the fingers, followed in fairly quick succession by flexion of the hand on the forearm, then of the forearm on the arm, and then adduction of the arm across the chest. Both arms appeared to be equally affected, and the spasms lasted a little over a minute, being followed by complete relaxation. Once or twice I thought the corners of the mouth were drawn down with the spasm, and the eyes were always rolled up, but there was never any squint or deviation of the eyes. The feet being Chinese crushed feet were not visible, and could hardly in any case have been affected, as but little muscular tissue can be left in these deformed members. But the most marked thing of all was complete paralysis of the diaphragm, the breathing being altogether costal. The lungs on examination revealed nothing abnormal, nor did the heart as far as it could be examined at the rate at which it was beating. Knee-jerks appeared to be absent; urine was still retained, and feces passed under the patient. Mental condition perfectly clear, and some pain was experienced with the spasms. The feeling of tightness of the tongue was still there, but there was no difficulty in swallowing. Brandy was easily swallowed, but neither that nor a hypodermic of strychnine seemed to quieten the heart's action at all, and the patient died shortly after I saw her. I would like to make it quite clear that there were never any general spasms; there was never any opisthotonos, and the relaxation between the spasms was complete. The only other note I would like to add is that I cannot help regarding the great rapidity of the pulse, when there were almost no other symptoms, as a commencing paralysis of the vagus, and this is still more borne out by the condition of the heart at the close of the illness, when even with complete paralysis of the diaphragm there was really no cyanosis, death being purely from heart failure.

My second case certainly is less complicated.

X—, a Chinawoman *æt.* 23, married, was brought to the hospital one day with the history that two nights previously she had suddenly become blind. Her own story was that she went to bed able to see all right, and woke up in the morning blind. She appeared a healthy girl, though naturally very much depressed by the circumstances under which she was placed. The only history I could get was that she had suffered rather recently from "fever," and had been dosed heavily with native drugs by a native practitioner. On physical examination there were but two things to be noted:—One was that her pupils were not of the ordinary size of a blind person's pupils, but were widely dilated, but did not react to light at all. The other point, which with so widely dilated pupils could be noticed without an ophthalmoscope, was the striking paleness of the retina. On ophthalmoscopic examination the vessels appeared contracted to mere threads, and the fundus was so white as hardly to

differ in colour from the disc. The girl, moreover, was so completely blind that she could not tell light from darkness. As there appeared to be no indication how such a case should be treated, she was put on a tonic, and the eyes left untreated except for a blister to the temples as a placebo (patients here are, if possible, even more urgent than at home for active treatment, and I did not want to lose sight of the girl). Under this negative treatment she was restored to health, her sight improving daily, and a month after her admission, when I again examined her eyes, I could detect nothing amiss. I may say that the first sign of improvement was accompanied by the regaining by the pupils of the natural size, and of their reaction. On looking up the books I see that quinine is credited with some such symptoms as I have narrated, when used for a long time in excessive doses. Now there is no question in my mind as regards this case that the girl had not been taking quinine, if for no other reason than that the drug is a very expensive luxury among the Chinese. I have tried in vain to find out what drugs they had given the girl, and failed altogether, partly on account of ignorance of the native names for plants, and partly from reluctance on the part of the people to say. There is, however, growing wild here in great profusion, and much used by the natives as medicine, the *Datura stramonium* plant, and the idea struck me that that might have been the drug. Whether or not that could have produced the symptoms I have described I am unable to discover.

Notes.

DR. FLETCHER has been appointed Medical Registrar and Demonstrator of Morbid Anatomy *vice* Dr. Calvert, who has resigned.

DR. THURSFIELD has been appointed Assistant Curator of the Museum.

DR. LANGDON BROWN has been appointed Examiner in Physiology to the Cambridge Local Examinations.

A. E. LISTER was placed first in the Entrance Examination for the Indian Medical Service.

THE Corporation of London has decided to invite all Medical Practitioners in the City to voluntarily notify to the Medical Officer of Health, at the Guildhall, any cases of phthisis occurring within the City of London, with the object of limiting the danger of infection by means of disinfection of rooms, etc.

The ordinary procedure in such cases will be that on receipt of a notification the house will be visited, disinfection will be offered, and a leaflet (prepared by the Medical Officer of Health) giving simple advice left with the friends.

The fee for notification will be the same as in the case of the other infectious diseases.

This is a step in the right direction, as it provides an opportunity of testing the scheme on a small area; but it is surprising to find how few cases are affected by the regulation; no one seems to live within the City boundaries when they come to the surgery in the mornings.

THE Anniversary Dinner of the Hospital was held in the Great Hall, on Wednesday, July 31st, the Treasurer, Sir Trevor Lawrence, being in the Chair. This function, which perhaps is better known as the "Buck Feast," is one of those institutions which serve to remind us, from time to time, of the great past of the Hospital, which has made the present possible.

THE Treasurer, in his speech, announced that a Bust of Her late Majesty Queen Victoria had been promised for the staircase of the Great Hall. He also referred to the debt which the Hospital owed to the King for all he had done during his long term as President of the Hospital, and reminded those present that the health of "The King" had never before been drunk in the present Hall.

FOR two and a half centuries at least this dinner had been held, and its origin was lost in obscurity; but from the old menus it was obvious that our forefathers had understood the art of dining well, though their tastes were directed to courses that more degenerate digestions might shrink from.

HE paid a high tribute to Mr. Cross, the Clerk of the Hospital, who having reached a limit of years when under other circumstances his resignation might have been considered, had been asked to continue in office at least until the critical process of extending the Hospital buildings had been satisfactorily concluded.

SIR TREVOR LAWRENCE also imparted the welcome news that the difficulty of acquiring part of the Christ's Hospital land had been arranged successfully with the aid of a Bill in Parliament, though some time must elapse before the actual terms of agreement could be settled by arbitration.

THE Hospital is now anxiously looking for a millionaire to buy the whole site of Christ's Hospital and present it to Bart's for the benefit of London's poor; in these days of open-handed charity such an idea, ensuring, as it would do, undying fame, should not be beyond the bounds of possibility.

A CHARITY that can for nearly eight centuries carry on its work with as little departure from the founder's scheme as this has done would not prove unworthy of some such trust being confided to it.

AS one looks down the lists in the Great Hall one sees that the men who made the City of London had a practical method of showing their confidence in the City's Hospital. On whose shoulders has their mantle fallen?

STRANGE are the uses of adversity. The publicity given to an unfortunate result from a well-known mode of treating aneurysm has given the treatment in question such a boom in the lay press as no record of successful cases could have evoked.

IT is to be hoped that the House Surgeon did not turn a deaf ear to the following eloquent appeal:—"Mr. Doctor,—Are you the kindness and generosity to make me the operation. I want because make me have much pain I upon to you. Your devoted friend T. P."

A REMARKABLE case is reported from Lourdes, so wonderful, indeed, was it that a passing word may not be amiss even in this JOURNAL. Twenty months ago a man was so badly crushed in a railway accident at Angoulême that he became completely paraplegic. Such a result of a spinal injury is by no means outside the limits of possibility, nor can the jury which awarded the poor sufferer £2400 damages in hard cash and an annuity of £240 be blamed for the practical form their sympathy took; but the sequel at Lourdes suggests that the man's brain had escaped the shock which shattered his "spinal marrow," for a few weeks after the lawsuit was settled he made the pilgrimage to the sacred grotto and was incontinently cured. Thus was the cruel tongue of suspicion silenced, and the patient freed from the dilemma of remaining paraplegic or branding himself a "Traumatic Neurosis."

La Druyère was not far wrong when he said, "Out of difficulties grow miracles."

A DUEL has lately taken place between the son of a celebrated novelist and a well-known journalist of Paris, in which it is reported that in the course of the encounter the tip of the sword of one of the combatants was observed to touch the ground. The duel was immediately interrupted, and under medical supervision the weapon was carefully and scientifically disinfected. It is gratifying to hear that in consequence of the extreme precautions observed a wound inflicted on one of the parties to the duel is proceeding satisfactorily.

No mention was made in the reports of the skin of the combatants having been prepared, but we imagine so obvious a precaution would scarcely be omitted. Duelling is shorn of its remaining terrors if a nice warm preparatory dressing can be donned before the fray.

A KORRESPONDENT writing from Staffordshire has sent the following example of local superstition which he has met with recently. They have probably seen many new centuries dawn, and evidently do not intend to hide their heads even before the early radiance of the twentieth.

Clock "running down."

In 1804 Mrs. S—, of D—, a village two miles from here, was very ill, and on going to see her one morning I found herself and her daughter quite prepared for, and resigned to, her immediate dissolution the old clock had "run down" in the night (*i.e.* the striking weight of the old "grandfather"). Much to her surprise, and to a certain extent her disappointment, she recovered, and consequently lost faith in her old clock, "which had never told a lie before." She later told me the following story, which I will try to give more or less in her own words:—"That old clock has only run down four times before—once when my grandmother died, once for my father, once for my mother, but the strangest of all was one morning, when I was working in the kitchen, it run down. Well, I knew it was not for me—I was all right; I went to our Liz in the garden—she was all right; so I knew it must be for my old man, who was gardener to the late Lord F— then. I went and fetched him home, although he said he was all right, put him to bed, gave him some gruel, and sent for Dr. F—. Dr. F— came and said there was nothing the matter with him; so I sent for Dr. H—, and he said there was nothing wrong; so then I sent for Dr. T—, who also came and said he was quite well, but I knew he wasn't; so I kept him in bed and fed him on gruel, and, d'you know, in three months' time he was dead. All the doctors said there was nothing wrong with him, but I knew the old clock was right."

EGYPT seems at present to be the Land of Promise. The first Egyptian Medical Congress is to be held at Cairo in December, 1902.

Amalgamated Clubs.

ST. BART'S.		R.I.E.C.	
CRICKET CLUB.			
ST. BART'S v. R.I.E.C.			
Played at Cooper's Hill, and resulted in a win for the home side.			
SCORES.		SCORES.	
C. F. Nicholas, b Ling	6	C. E. Scovell, b Scoones	54
H. E. Scoones, ct De Smidt, b Carr	26	F. Barry, b Greaves	20
W. S. Nealor, b Scovell	42	E. A. Hopkins, b Nicholas	3
H. S. Greaves, ct Carr, b Scovell	8	T. B. S. Thubron, ct Phillips, b Nicholas	12
C. A. Anderson, ct Thubron, b Carr	11	L. P. De Smidt, b Nicholas	3
G. G. Ellett, b Carr	0	T. Carr, b Elliott	1
T. M. Body, b Shore	0	C. E. Colbeck, st Anderson, b Corbin	47
J. Corbin, ct Colbeck, b Shore	0	P. T. Dolmett, ct Elliott, b Body	23
L. L. Phillips, lb-w, b Carr	0	H. C. Agnew, ct Nealor, b Scoones	20
W. H. Hamilton, b Shore	2	C. G. Ling, lb-w, b Scoones	10
C. Elliott, not out	4	H. A. Shore, b Corbin	0
H. S. Wilson, b Shore	0	H. J. Hope, not out	4
Extras	13	Extras	15
Total	114	Total	218

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
Greaves	19	1	59	1
Anderson	6	0	18	0
Corbin	7	0	45	2
Nicholas	7	3	17	3
Elliott	7	2	10	1
Scoules	12	1	31	3
Body	5	0	23	1

ST. BART'S v. SUBBITON.

Played at Surbiton, and resulted in a draw in favour of the Hospital. H. S. Greaves was very unlucky not to get his hundred after scoring 99 by good cricket.

SCORES.

ST. BART'S.		SUBBITON.	
C. N. H. Howell, ct Scarf,	25	Finlason, ct Nicholas, b	21
b Finlason	10	Howell	0
C. A. Anderson, b Francis	4	Francis, run out	6
W. S. Nealar, b Finlason	99	Davenport, b Greaves	23
H. S. Greaves, ct Finlason,	52	G. Brann, ct and b Nicholas	0
b Brann	6	Castle, ct Nealar, b Elliott	0
C. F. Nicholas, st Hickson,	17	Hickson, b Nicholas	4
b Finlason	17	Scarf, not out	17
G. G. Ellett, st Hickson, b	3	T. Castle, b Elliott	0
Finlason	12	Howell, not out	12
L. Orton, ct and b Brann	25	Clayton did not bat.	0
T. M. Body, run out	3	Baron von Ernsthause did	0
C. Elliott, b Brann	12	not bat.	0
W. H. Hamilton, not out	6		0
B. Hudson, b Finlason	12		0
Extras	6	Extras	22
Total	261	Total (7 wickets)	160

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
Howell	12	7	27	1
Greaves	12	5	32	1
Nicholas	9	1	26	2
Elliott	9	3	26	2
Anderson	3	1	4	0

JUNIOR STAFF XI v. HOSPITAL EMPLOYEES C.C.

Played at Winchmore Hill on Saturday, July 20th, resulting in a win for the Junior Staff by 135 runs.

SCORES.

JUNIOR STAFF.		HOSPITAL EMPLOYEES C.C.	
H. S. Ward, retired	38	W. Stowe, l-b-w, b Ridout	10
J. A. Willett, b Tutton	10	W. S. Herbert, l-b-w, b	2
A. T. Pridham, l-b-w, b	8	Ridout	0
Stowe	76	Johnson, b Hawes	13
S. Hey, b Stowe	8	Denton, c and b Hawes	7
L. E. Whitaker, b Herbert	8	H. Stuchbury, l-b-w, b Hawes	8
C. A. S. Ridout, not out	23	W. Tutton, b Hawes	1
C. S. Hawes, not out	0	W. Spalding, c Hey, b	0
A. H. Hayes	0	Ridout	7
W. P. S. Bransom, } did not	0	W. Wilson, b Whitaker	0
A. H. Bostock, } bat.	0	Day, c and b Ward	10
H. B. Gibbins,	0	Hearn, b Whitaker	0
Innings declared closed.	0	Miller, not out	0
Extras	21	Extras	5
Total	198	Total	63

HOSPITAL EMPLOYEES C.C. v. MR. ANDERSON'S XI.

Played at Winchmore Hill on Saturday, August 24th, resulting in a win for Mr. Anderson's team by 108 runs.

SCORES.

HOSPITAL EMPLOYEES.		MR. ANDERSON'S XI.	
Muirhead, b Body	11	S. Hey, c Fitchie, b Herbert	34
Roberts, b Body	18	H. S. Ward, c and b Herbert	9
H. Stuchbury, c Pollock, b	30	A. H. Bostock, c Roberts, b	10
Anderson	0	Herbert	22
Herbert, b Body	0	H. E. Boyle, b Herbert	8
Fitchie, c Ward, b Dody	8	H. G. Pinker, c Wilson, b	8
Evans, b Body	19	Herbert	62
J. Stuchbury, not out	16	W. E. Lee, not out	34
Deane, l-b-w, b Anderson	0	T. M. Body, c Deane, b	0
Day, c and b Anderson	1	Fitchie	0
Wilson, b Anderson	0	C. A. Anderson, st Martin,	0
Martin, b Anderson	0	b Stuchbury	0
Gabbons, st Bostock, b Lee	0	A. H. Pollock, c Muirhead,	10
		b Stuchbury	26
		L. R. Tossell, st Martin, b	0
		Muirhead	0
		A. R. Neligan did not bat.	0
		N. A. Connolly did not bat.	0
Extras	9	Extras	14
Total	112	Total	220

BATTING AVERAGES.

	No. of	Not	Total	Highest	Ave-
	innings.	out.	runs.	score.	rage.
H. N. Burroughes	13	2	405	113	30.7
W. E. Honball	11	1	306	67	30.6
C. A. Anderson	18	3	449	70	29.9
W. S. Nealar	19	0	421	174	28.3
L. Orton	12	3	192	52	20.1
C. M. H. Howell	13	0	259	84	19.0
C. F. Nicholas	20	2	288	52	16
L. L. Phillips	8	1	104	29	14.8
G. F. Page	16	6	126	33	12.6
L. V. Thurston	6	0	62	47	10.2
H. T. Wilson	6	1	48	22	9.6
H. E. Stanger-Leathes	9	1	77	29	9.6
B. Hudson	4	0	37	12	9.2
G. C. Ellett	9	0	70	31	8.7
G. H. Adam	14	3	92	17	8.3
C. Elliott	5	1	26	9	6.5

BOWLING AVERAGES.

	Overs.	Maidens.	Runs.	Wickets.	Avg.
C. A. Anderson	59	5	224	15	14.9
W. S. Nealar	29	1	148	9	16.2
G. H. Adam	184	27	676	35	19.3
C. F. Nicholas	51	12	195	10	19.5
H. E. Stanger-Leathes	200.6	33	660	32	20.6
H. N. Burroughes	23	3	86	4	21.5
C. M. H. Howell	85	13	332	14	23
W. E. Honball	110	13	390	17	23.9
G. F. Page	119.5	16	470	18	26.1

Also bowled:

B. Hudson	1	0	2	1	2
L. L. Phillips	3	2	21	2	10.1
C. Elliott	30	7	79	3	26.3

Reviews.

TEXT-BOOK OF MEDICINE. Edited by GEO. ALEX. GIBSON, M.D., etc. Two Volumes, pp. 824 and 910, with 122 illustrations. 25s. net. Young J. Pentland.

This text-book is the work of some forty contributors, liberally chosen, though, as might be expected from the professional location of the editor, preference is given to Scotch physicians. The St.

Bartholomew's School is represented by Sir Lauder Brunton and the late Dr. Kanthack, concerning whose lamented death a note is inserted in the preface. Dr. Kanthack was engaged upon his article dealing with the general pathology of disease at the time of his death, and it is being completed by Professor Sims Woodhead. The article is a masterly exposition of Kanthack's latest views upon the matters dealt with, and should be read by all who are in touch with the subject so beloved of our late lecturer on pathology.

There are many articles which call for special commendation. We may mention particularly Dr. Sidney Martin's chapters on Diseases of the Stomach, Dr. Oliver's on Diseases caused by Chemical Substances, Professor Stockman's upon Diseases of the Blood, and Dr. Mott's upon Diseases of the Brain. All these sections are necessarily concise, but we look in vain for the omission of any important points, and it must be remembered that the work is a "text-book," not a "system."

Dr. Jamieson contributes some 120 pages upon skin diseases, a subject which we consider should never be omitted from a text-book of medicine. The desirability of skin diseases being taught by a specialist at our large hospitals by no means renders their exclusion from medical text-books a wise measure. Dr. Jamieson's name is a sufficient guarantee for the usefulness of this particular article.

We can confidently recommend the book to our readers as a reliable text-book, in which the subject-matter is kept within the bounds of assured facts, and therefore within the limits of ordinary reading.

A MANUAL OF SURGICAL TREATMENT. By W. WATSON CHEYNE, F.R.S., and F. F. BURGHARD, F.R.C.S. In six parts. Part V, including the Intrinsic Diseases of the Nose, Ear, and Larynx, by H. LAMBERT LACK, F.R.C.S. Price 18s.

This volume is fully up to the high standard of those which preceded it, and we can here only indicate the best of the various articles it contains and the most important of the omissions.

The last part of the book is given up to the consideration of the treatment of the diseases of the ear, nose, and larynx, and these special diseases are discussed by a surgeon who devotes himself to this branch of surgery. This is as it should be, and as a result the subjects are thoroughly well dealt with, and the methods of treatment clearly and authoritatively stated.

We think that by far the weakest part of the whole volume is the portion concerned with the plastic surgery of the face and the treatment of trigeminal neuralgia. The various plastic operations devised for the cure of microstoma, restoration of the lip, and similar deformities, are hardly ever done, and the majority of those who read the account of them will probably never even see a case which calls for their performance.

Then, again, in the chapter on the treatment of neuralgia there is no obvious need to quote *verbatim* from the authors the accounts of the operations which have been done.

If the method of Professor Rose is so important as to require four closely printed pages for its elucidation, it would be quite as well to see that the text is reasonably illustrated, and not to inflict the diagram on p. 134 on the reader. There is nothing more uninteresting than to read these tedious descriptions of long operations even when the text is well illustrated, and only a stern sense of duty carried us through the chapter we have referred to.

In marked contrast the treatment of harelip and cleft palate is well described and clearly illustrated.

We must confess to a little disappointment on reading the chapters dealing with fractures of the skull. The theories as to the exact method of causation of fractured base are very imperfectly stated, and scarcely anything is said about its diagnosis. It is also quite incorrect to describe the escape of cerebro-spinal fluid from the nose as a common symptom of fracture of the anterior fossa, and we are sure that the hopeful prognosis in most cases of Jacksonian epilepsy treated by trephining is not justified by experience.

The chapters on the tumours of the jaws are well worth reading. No unnecessary operations are described, and the descriptions are very clear, while the articles dealing respectively with cut throat and tracheotomy are the best in the book.

In considering the treatment of cancer of the larynx we notice that in some cases complete laryngectomy is recommended, together with removal of glands from both anterior triangles. It is stated that the mortality is slight and the functional result good.

If this statement is correct we can only wonder that the operation has been abandoned in late years by many well-known surgeons.

Coming now to the latter part of the book, dealing with the intrinsic diseases of the nose, ear, and larynx, we can safely say that it furnishes the best account of their treatment hitherto published in a book on general surgery.

The account of laryngeal paralysis is, however, very incomplete, no mention whatever being made of unilateral paralysis. The early recognition of this condition is so important that no doubt this omission is accidental.

In conclusion, the book is admirably bound and printed, and, with a few exceptions, well illustrated.

A MANUAL OF MEDICINE, edited by W. H. ALLCHIN, M.D., etc. (Vol. III, Diseases of the Nervous System, pp. 417, price 7s. 6d. net. Messrs. Macmillan.)

We have already had occasion to congratulate Dr. Allchin upon the first and second volumes of this manual. The third is no disappointment. It has the advantage of being a small text-book of nervous diseases in itself, and may be purchased in this light; in this way it supplies a long-felt want. The large work of Gowers' is too compendious for most students. There are smaller text-books, we know, but as yet none which it gives a teacher any other feeling than one of pity to recommend.

Here, the great desideratum for the student—a full and lucid introduction to nervous diseases, written on general anatomical and physiological grounds—is provided by Professor Sherrington and Dr. W. Aldren Turner, and is well illustrated by useful diagrams. A careful perusal of this section will render the description of the actual diseases which follow much more easily understood. Until the student realises that the few scattered remnants of his former (it may be) dubious knowledge of the anatomy and functions of the brain and spinal cord are totally insufficient as a basis for his reading in this branch of medicine, he will never cease to find—as one so often hears it said he finds—nervous diseases the *pons asinorum* of his curriculum. As a means of overcoming this difficulty we recommend the book before us as likely to be of great service.

There are twenty-seven diagrams and six coloured plates in the text. This is better, but we shall still have a welcome for the text-book which, in this particular branch, multiplies each of these by two or three.

LESSONS ON MASSAGE. By MARGARET D. PALMER. Pp. 234. Price 7s. 6d. net. Baillière, Tindall, and Cox.

In this book we have, in a somewhat expanded form, the instruction given to the nurses at the London Hospital by the authoress, who has had considerable experience in this special branch of nursing.

More than half of the work is devoted to anatomy, perhaps with but little profit to the reader. It is difficult to estimate the capacity of others for acquiring a knowledge of the subject by reading only; for ourselves we feel that there is so much detail that it would be a hopeless task to follow the purely descriptive part without some practical knowledge of dissection; yet we cannot suggest any means by which the anatomical teaching could be made less prominent with profit to the pupil.

When the parts dealing with the actual massage are reached we have little fault to find. The various methods and their application are excellently described, and without a special knowledge of the subject there is no difficulty in grasping the writer's meaning. The illustrations are excellent, and make the letterpress easy to understand.

There is, perhaps, rather a tendency to discuss the treatment of disease at length, and here the ground becomes very dangerous. It is not the object of a book of this kind, addressed as it is to nurses, to even appear to offer advice on the treatment of diseases; otherwise it might be concluded that the treatment of intussusception is "massage." The condition may have been relieved by this process in isolated cases, or the diagnosis may have been wrong.

While paying a deserved tribute to the subject-matter of the book, we cannot but complain of its literary style. It does not follow that because authors have something to say, they are justified in offering to the public sentences which are either faulty in construction or obscure in meaning.



## Calendar.

September, 1901.

Tues., Sept. 3.—Sir William Church and Mr. Willett's duty.  
 Fri., " 6.—Dr. Gee and Mr. Langton's duty.  
 Tues., " 10.—Sir Dyce Duckworth and Mr. Marsh's duty.  
 Fri., " 13.—Dr. Hensley and Mr. Butlin's duty.  
 Tues., " 17.—Sir Lauder Brunton and Mr. Walsham's duty.  
 Fri., " 20.—Sir William Church and Mr. Willett's duty.  
 Mon., " 23.—Examination for Open Scholarships in Science, also for Jeffereson and Preliminary Scientific Exhibitions begins.  
 Tues., " 24.—Dr. Gee and Mr. Langton's duty.  
 Fri., " 27.—Sir Dyce Duckworth and Mr. Marsh's duty.

## Examinations.

UNIVERSITY OF LONDON.

*Preliminary Scientific and Intermediate Science (conjointly).*  
 A. M. Jukes, third class honours in Zoology.

*Preliminary Scientific.*

*Entire Examination; First Division.*—P. L. Giuseppi. *Second Division*—B. H. Barton, S. S. Rendall, S. Upton.  
*Chemistry and Physics only.*—G. J. Eady, H. R. Prentice, S. A. Tucker.  
*Biology only.*—A. T. W. Forrester, F. G. Hodder Williams, C. R. Hoskyn, N. H. Walker.  
*Intermediate Examination in Science; Second Division.*—A. A. Abrahams, G. W. Lloyd.  
 Honours candidate recommended for a pass.—D. W. Hume.  
 Exempt from Examination in Chemistry and Physics at the Preliminary Scientific Examination.—E. T. Glenny.

*Conjoint Examination Board.**First Examination.*

*Chemistry.*—E. J. Balchin, J. G. Gibb, C. G. Grey, W. H. Harvey, J. R. Lloyd, C. B. Mora, W. S. Nealer, E. H. Shaw.  
*Pharmacy.*—A. K. Armstrong, R. C. P. Berryman, R. A. Bowling, C. P. Charles, W. R. Collingridge, P. A. Dingle, G. J. Eady, C. Elliott, R. V. Favell, C. H. Fernie, W. E. L. Fowler, J. G. Gibb, L. Grey, J. P. Grithn, E. W. D. Hardy, T. A. Kilby, H. J. S. Kimbell, C. Loddiges, W. G. Loughborough, J. E. R. McDonagh, R. C. P. McDonagh, E. H. Shaw, J. F. Trewby, J. R. R. Trist, H. C. Waldo, J. A. West, C. O. O. Williams, L. E. Wright, H. N. Wright, A. C. Wroughton.  
*Elementary Biology.*—L. D. Ching, M. R. Coalbank, C. G. Grey.

*Second Examination.*

*Anatomy and Physiology.*—B. N. Ash, W. S. Edmond, C. D. M. Holbrook, H. M. Huggins, A. M. A. James, E. B. Lathbury, A. H. Muirhead, F. M. Newton, C. W. O'Brien, A. F. C. Pollard, H. H. Rolfe, H. B. Scott, J. E. L. A. Turnly, A. D. White, F. E. Whitehead.

*Final Examination.*

The following have completed the final examinations:—C. R. H. Ball, S. B. Green, F. Gröne, E. I. P. Fellow, E. E. Young, F. P. Connor, W. B. Knobel, L. E. Dickson, A. J. Fairlie-Clarke, L. M. Morris, E. W. Price, K. T. Thorne, A. B. Olsen, J. B. Cox, W. V. Wood, D. S. Sandiland, W. E. L. Davies, R. G. Whiting.

## Appointments.

CORNISH, C. V., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Wolverhampton Hospital.

GRÖNE, F., M.R.C.S., L.R.C.P., appointed House Physician to the Chest Hospital, City Road.

HUGHES, J. B., M.A., M.B., B.C., appointed Hon. Medical Officer to the Macclesfield General Infirmary.

MELLOR, A. J., B.A., M.R.C.S., L.R.C.P., appointed Assistant House Physician to the Wolverhampton Hospital.

## New Addresses.

CRUMP, A., Park Lane, Welshpool, Montgomery.  
 MARKS, L. FREEMAN, Rose Bank, Mumbles, R.S.O., Glamorgan-shire.

PHILLIPS, L. C. P., Kasr-el-Aini Hospital, Cairo, Egypt.  
 THORNE THORNE, R., "Essendene," Chobham Road, Woking.

## Birth.

GUNDLACH.—On July 26th, at Holmedate, Fletching Road, Clapton, the wife of J. Gundlach, M.R.C.S., L.R.C.P., of a daughter.

## Marriage.

MARKS—BURGESS.—On August 15th, at West Cross, Leonard Freeman Marks, M.B. Lond., M.R.C.S. Eng., of Rose Bank, Mumbles, R.S.O., Glamorgan-shire, son of T. Septimus Marks, Esq., of Highgate, London, to Ethel Osmond, second daughter of J. H. Burgess, Esq., of The Croft, Mumbles.

## St. Bartholomew's Hospital



## JOURNAL.

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## St. Bartholomew's Hospital Journal.

SEPTEMBER, 1901.

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

## Editorial.

THE Report of Mr. Brodrick's Committee, appointed to consider the Reorganisation of the Army Medical Service, has at length been published. Of the importance of such an expression of the views of the men who formed the Committee there can be no question, and it is unlikely that they will meet with any but a favourable reception from the Government, especially when we consider that Mr. Brodrick himself was chairman of the Committee.

The presence of so large a proportion of medical men in civil practice on the Committee makes it evident that the

Government wished to increase rather than diminish the scope of the purely medical work, instead of, as has hitherto been the case, sacrificing the scientific to the administrative duties.

The 'Lancet,' in commenting on the Report, gives its readers a valuable hint,—that to appreciate its merits it should not be read merely to see how this or that grievance has been met. The recommendations of the Committee contemplate making a fresh start altogether, not tinkering with the old constitution.

Bearing in mind the numerous extra-professional duties which an army medical officer is bound to carry out, often to his detriment as a man of medicine, there is no doubt that the Report aims at preserving at all hazards the Art and Science of Physic; hence the proviso suggested that candidates who pass the entrance examination for the Royal Army Medical Corps, while holding a resident appointment in a recognised civilian hospital, or appointed thereto at such a date as will permit them to take up their duties immediately after they have passed the entrance examination, shall be allowed to count the period of such appointment towards seniority, pension, or gratuity, but shall receive no pay from army funds. Nothing could indicate more clearly than this the determination to estimate at its highest value clinical experience; in effect it is extending the most favourable terms to a class who have hitherto been discouraged from joining the R.A.M.C. on account of the seniority they would lose while holding a resident appointment in a civilian hospital. Whether this scheme will commend the Army Medical as a profession to men who have been "residents" is open to question perhaps, but there are further inducements held out to candidates at large.

Facilities are to be granted to officers in the service for continuing or resuming their studies at civilian hospitals after serving three years. Six months will be allowed for this purpose, at the end of which time an examination will be held in Medicine, Surgery, Hygiene, and Military Sanitation, also Bacteriology and Tropical Diseases. This

examination will be to a certain extent selective, as acceleration of promotion may be recommended on its results. So for every step in rank the same measures are advised whereby an officer shall, before presenting himself for examination for promotion, be given an opportunity of brushing up his knowledge in a civil hospital.

Encouragement will be given to specialisation, but to qualify for "specialist appointment" at least 70 per cent. of marks must be obtained on examination in the special subject selected.

Further the scale of pay has been revised and, the proposed rates are for:

	£	s.	d.
Lieutenant ...	323	10	0 per annum.
Captain ...	379	15	2 up to
	477	15	2 according to length of service.
Major ...	587	12	10 to
	632	12	10
Lieut-Colonel ...	713	15	4 to
	804	15	4
Colonel ...	963	10	10
Surgeon General	1500	0	0
Director General	2000	0	0

These raised rates of pay will in themselves, we have little doubt, decide a certain number of men who would otherwise have hesitated, for with all the necessary expenses it is possible not only to live on the pay, but under some, possibly exceptional, circumstances, to save money on first joining.

Professor Ogston adds a suggestion which to a non-military mind appears the most valuable in the whole report, namely the formation of a Sanitary Corps consisting of officers specially charged with the duties of carrying out proper sanitary measures in peace and war; a corps which might under satisfactory management prove a greater attraction than any other branch of the Army Medical.

But considering the Report and its effects if carried out without substantial modification, there is evidence, as we have said, of a desire to encourage even in the Royal Army Medical Corps, the study of medicine for its own sake. This has always been at the root of the mischief; changing titles, altering uniforms, decentralisation alternating with centralisation, have been the efforts of groping minds, not knowing what they wanted or how to get it, but appreciating the fact that for some obscure reason medical service with the army did not attract the medical profession. Pay, rank, and titles are quite secondary to the main fact that most doctors are compelled, sooner or later, to make a hobby of their profession, and this was denied them on entering the army.

The idea of permitting an occasional stimulus to a man, perhaps getting on in years, by sending him back to a general civilian hospital where surgery and medicine are

not merely advancing but being made to advance, is the most probable solution of the great difficulties which have in the past beset the R.A.M.C.; but the scheme for perpetual examination should be nipped in the bud. It was a shrewd saying of Sir Thomas Browne that "We do but learn to-day that which our better judgments will unlearn to-morrow," and to nothing is it more applicable than to the knowledge acquired for purposes of examination.

If under the new conditions, whatever they be, scope is given to the younger men to practise their profession, instead of, as is now the case, reverting to the post of "Clinical Clerk;" if something like independence of thought and action are, we will not say encouraged, but tolerated; if the "senior to you—correct diagnosis!" spirit is stamped out; then and then only will it be possible to honestly advise students of medicine to look in the direction of the R.A.M.C. for a career and profession.

### Cervico-brachial Neuralgia.

A Clinical Lecture delivered by DR. GEE.

(Reported by DR. T. J. HORDER.)

**B**Y neuralgia we mean pain situated in the course of a nerve. There are as many neuralgias as there are sensory nerves. The following varieties of neuralgias are well-known examples:—*Facial* (the fifth cranial nerve); *cervico-occipital* (the cervical plexus); *cervico-brachial* (the brachial plexus); *intercostal*, *lumbar-abdominal*, *anterior crural*, and *obturator* (nerves of the lumbar plexus); *sciatica*, a very common disease (the sacral plexus).

Here's a shabby old book, containing a fine medical essay; the author is Dominico Cotunnio (known as Cotunnus) of Naples, who wrote in the eighteenth century. Cotunnus was the discoverer of sciatica, and therefore of neuralgia. Up to his time sciatica meant two things,—sciatica as we know it, and rheumatoid arthritis of the hip joint; Cotunnus was the first to distinguish "nervous" sciatica from the pain due to arthritis. He also discovered anterior crural neuralgia, which he called anterior sciatica as against the posterior form, and this cervico-brachial neuralgia of which we are going to speak. Using the word sciatica as he did—synonymous with our word neuralgia—he called this cervico-brachial neuralgia cubital neuralgia, and in this book is a good description of the disease. The name of Cotunnus\* is therefore important; he had an eye to see that this affection was pain due to a nerve.

\* *Liquor Cotunnii*, the endolymph of the ear, preserves the name of the same man.

There is at present in Luke a publican, æt. 59, suffering from cervico-brachial neuralgia. "Seven weeks ago pain began under the right armpit, and struck through from the back of the shoulder into the breast. It afterwards went up and down the arm like wires. The use of the arm was lost from the third or fourth day"—lost, because it hurt to use it, not because it was paralysed. "For the last few days he has had pain in the left arm. He had syphilis forty years ago. Fifteen months ago the right arm was put out of joint at the shoulder.

*Causes of the disease.*—1. The man being a publican suggests the possibility of *alcoholic neuritis*; this is conceivable, but so far as I know alcoholic neuritis is not thus limited.

2. *Was it syphilis?*—There is a syphilitic neuritis, but here the syphilis occurred forty years ago, and I have not seen a case of syphilitic cervico-brachial neuritis.

3. *Dislocation of the shoulder.*—I have very little doubt that this was the cause of the present disease. Fifteen months ago the right shoulder was put out of joint; injury to nerve-trunks is a very frequent cause of neuralgia, and surgeons are more likely to meet with this than physicians.

Let me read the account of an interesting case which bears upon this question of injury. It was reported by Mr. Alexander Denmark in 1813.

"Henry Croft, a healthy young man, belonging to the 52d regiment, was wounded on the night of the 6th April, 1812, at the storming of Badajos. A musket ball entered the triceps extensor cubiti, about one and a half inch above the inner condyle of the os humeri, which, grazing the inside of that bone, passed obliquely downwards through the brachialis internus, and out anteriorly near the bend of the arm. The wound soon healed, and without manifesting any particular morbid symptom during the cure. On his admission into this hospital I found him labouring under excessive pain, which the largest opiates could not assuage, with almost constant watching. The little sleep he had, if it could be called such, was disturbed by frightful dreams and starting. I always found him with the fore-arm bent, and in the supine posture, supported by the firm grasp of the other hand; the wrist also bent, being unable to move it into any other position by the voluntary exertion of its own muscles. He could suffer me to extend the hand, but with increased pain. It always, however, on the removal of the extending power, fell into its former bent situation. The act of pronation he could also suffer me to perform, but in like manner with increase of pain. A small tumour could be felt in the site of the wound on the anterior part of the arm, which he could not bear to be touched without evincing additional torture. He described the sensation of pain as beginning at the extremities of the thumb and all the fingers, except the little one, and extending up the arm to the part wounded. It was of a burning nature, he said, and so violent as to cause a continual perspiration from his face. He had an excoria-

tion on the palm of the hand, from which exuded an ichorous discharge. The cause of this he ascribed to a shell rolling over it. His agonies, he observed, were insufferable, depriving him of sleep and the enjoyment of his food, for which he had sometimes an appetite. He declared himself incapable of enduring it longer without some relief, and earnestly requested the removal of the arm. Before proceeding to any operation I recommended him to try the effects of the warm and vapour baths, anodyne embrocations, etc., but from none of these he experienced any alleviation of his sufferings.

"I proposed to my patient the possibility of saving the limb, and relieving the pain, by cutting down upon the nerve, and removing a part of it above the wound, which he willingly consented to, but observed that he would rather have the arm amputated at once than run the risk of a second operation. In a consultation which I held with my colleagues upon this case, when we considered the chance of failure together with the injured state of the arm and contracted elbow-joint, we determined on the propriety of amputation. I immediately performed the operation, and with instantaneous relief to my patient. He was discharged cured in three weeks, having in that time rapidly recovered both his health and strength.

"On dissecting the arm I traced the radial nerve through the wounded parts. It seemed to be blended with, and intimately attached to them, for the space of an inch. It had been wounded, and at the place of the injury was thickened to twice its natural diameter, and seemed as if contracted in its length. This contraction, I thought, partly accounted for the bent position of the arm, and the increased pain on attempting its extension; but on further examination I was surprised to find, on dividing the fibres on the posterior part of the wounded nerve, that there was a small portion of the ball firmly imbedded in it, which had been driven off by grazing the bone. This description of injury more fully accounts for the exquisite pain felt by the patient. The os humeri was discoloured where it was grazed by the ball, and the humeral artery was uninjured! The nerve was evidently thickened both above and below the wound. Would the division of the nerve, and cutting a piece out of it, have been attended with success?"

No doubt it would, but this happened one hundred years ago, before the era of chloroform, and no dissecting of nerves was attempted when operations could only last for one or two minutes at most.

4. *Overwork.*—The disease is one form of writer's palsy, not necessarily affecting all the branches of the plexus, but only some. Excessive piano-playing may produce it, and, amongst the poor, overworked washerwomen are liable to the affection.

5. *Exposure of the neck to cold.*—I once saw an American gentleman on account of cardialgia, from which he suffered in a severe form. He was a very "painful" person,—

"neurotic," as he would be called nowadays. The cardialgia recovered, but as he was walking in Piccadilly in a strong north-east wind he was "struck" by the wind in the neck: an attack of cervico-brachial neuralgia supervened.

6. *Part of a multiple neuritis.*—A lady æt. 36 years, being at the time very subject to headaches, and therefore again a person predisposed to painful affections, first noticed aching pains in the soles of the feet and up the legs, increasing in severity. This was followed by pain in the left shoulder, continuing for some months. On examination there was atrophy of all the muscles, including the deltoid and infraspinatus; the extensor secundi intermedii pollicis was completely paralysed. Six months later there were neuralgic pains in one or two intercostal nerves of the left side, also in the legs. There had been supra-orbital and infra-orbital neuralgia off and on throughout. When neuritis is so universally distributed as that it is always right to suspect the existence of some poison,—alcohol, lead, arsenic, diphtheria, etc. We were not able here to discover it, and this is not seldom the case.

7. *By the nerves being involved in a tumour of the neck.*

A lady æt. 46 years suffered from pain and weakness of the right arm for three years. When seen she was suffering from well-marked cervico-brachial neuralgia, with tenderness just above the clavicle, where there had been an abscess in childhood. For some years she had been accustomed to lean her arm out of bed to support the head of her child. Neither of these things was the cause of the disease, however. Nothing more happened until a sarcomatous tumour appeared in the neck, from which she died ten months after she was seen. It is possible that the abscess had something to do with the origin of the sarcoma; mammary abscesses are not uncommonly followed by cancer.

It is obvious from what I have said that it is not always possible to detect the cause of the disease at the time.

Turning now to our own patient, what were the signs of the disease in his case? His condition on admission was as follows:

*Right arm.*—"Pain in the shoulder, shooting down the arm. Tenderness over the brachial plexus above the clavicle, over the nerve-cords in the axilla, over the ulnar nerve behind the elbow, over the musculo-spinal and median nerves," so all the main nerves of the arm were affected. "There is some wasting of muscles, especially of the abductor indicis. The deltoid is not wasted," so we suppose the circumflex nerve to have escaped. "The grasp is weak, the movements of the shoulder-joint very weak. Sensation: there is loss of tactile sense all over the little finger and the ulnar border of the ring finger;" therefore the ulnar nerve suffered more than the others, and this is very commonly the case.

He could not move the arm at all, nor would he let us move it without the greatest possible pain. Therefore the

question of disease of the shoulder-joint arose. To this I shall refer again later.

The pain in cervico-brachial neuralgia is more or less constant, and liable, like all neuralgias, to paroxysms. As to the severity of these, think of the soldier of whose attacks I read to you just now. Another case illustrating the severity of the paroxysm in cervico-brachial neuralgia is one described by Dr. Buzzard, occurring in a woman aged 65 years. "The patient was suddenly attacked with violent pain in the right arm, in the situation of the middle of the biceps muscle anteriorly, and she had never since been altogether free from it. But daily and nightly she would have, besides, sudden paroxysms of agony—generally four or five times a night. In these the pain was not constant to one situation. It would attack the front of the arm, and run down on the middle of the forearm to the ring and little fingers; or it would commence at the bend of the elbow, and then run down to the thumb. At other times, attacking first the thick part of the arm, it would extend like lightning to the shoulder, reaching sometimes to the back of the neck." (Hence the name *cervico-brachial neuralgia*.) "Whilst examining her she was seized with such a paroxysm, and almost fell from the chair in the writhing of her body which the pain caused. Her face and neck became vividly red during the paroxysm, which lasted perhaps half a minute. Her aspect during its continuance recalled exactly the appearance of a patient suffering from tic-douloureux." And I quote this case to illustrate that the paroxysm of pain may be as bad as in this other severe form of neuralgia.

*Pain*, then, is the main symptom. If the motor branches of the plexus suffer, which they always do in severe cases, there is more or less *palsy* of certain muscles. This may be accompanied by one or both of two other conditions: *spastic rigidity* of the fingers, and *muscular atrophy*.

*Diagnosis.*—It is interesting to notice that this case raised just that point in diagnosis which Cotunnus was the first man to settle: was the disease in the joint or in the nerve,—only here the joint concerned was the shoulder, not the hip. At first we were quite unable to say whether it was rheumatoid arthritis or neuralgia. One thing I thought important: the deltoid was not atrophied. Now in chronic affections of a joint the extensor muscles acting on that joint are usually more or less wasted. Thus, in hip disease one of the best signs is atrophy of the buttock on the affected side, seen on examining the patient with his back to you. But this absence of wasting of the deltoid was rather a small point to build an opinion upon. We had a better means of deciding the point, and that was by examining the shoulder under an anæsthetic. We did this, and found that the movements were perfectly free in all directions. There was, therefore, nothing the matter with the joint, and the diagnosis was clear.

So much for the diagnosis of the disease. In all dis-

eases it is important to diagnose the *cause* also, with a view to its removal. (The X rays would have greatly assisted in Denmark's case.)

*Treatment.*—(i) The first thing—any way the patient thinks so—is to remove the *pain*. Fomentations and anodyne liniments are hopeless. Treatment must be much more decisive—the subcutaneous injection of some anodyne; and I think the best to begin with is cocaine. This is what I generally use; and I usually find it sufficient, as it was in this case. A sixth or an eighth of a grain must be injected over the shoulder, where there is most pain. It is always best to make injections where the patient feels the pain most. At present the pain is in our case very considerably relieved, but is not gone. One reason for the selection of cocaine is that the drug is not so well known, and there is therefore less chance of the patient getting into a cocaine habit than into a morphia habit, were morphia used. This applies more to sciatica; I have known several patients become confirmed victims to the morphia habit after sciatica. Still, morphia is the heroic remedy if cocaine fails, and you must use it till the pain is relieved.

(ii) Keep the part at perfect *rest*. Bed must be insisted upon if the patient is very bad. But this is in itself not sufficient; it is important to have a sling, or bandage the arm to the side. If the patient is up one of these is quite essential. And the sling must be put on properly: you must always do it yourself; instructions are no good. The important point is to see that the *elbow* is supported, and not only the wrist. In a bad case it is best to make a boat of leather, and not to trust to a sling; then the whole can be bound to the side by a soft bandage.

(iii) If the pain is now relieved, or was not severe from the first—and you should not use hypodermic injections for slight pain,—apply hot bottles freely, as hot as they can be borne. In sciatica this treatment by local heat is most useful. Some say "iron the patient," but hot water is just as good, only it must *be* hot. The proper direction to give the patient is that the water should be a little hotter than can be borne. If the pain is very local a blister may do good, and though I spoke rather contemptuously just now of anodyne liniments for severe cases, in slight cases they have their place: aconite and belladonna liniment or salve are the best. If liniments are used they must not be spared, and the patient must not use them himself. The preparation should be applied from a saucer on cotton wool; not rubbed in stingily, but freely for three or four minutes a good many times a day. (It is very desirable that persons using poisonous liniments like these should wash their hands well; I have known them suffer severely for lack of this precaution.)

After a time the pain often does become local, settling in one point; then these local applications are useful.

(iv) Massage, *provided it be gentle*, is useful. The tendency

always is to be too rough, the masseur so often wanting to do great things, and therefore too much. This treatment is only to be applied when the disease has become chronic, not during the acute stage; it is to be done not merely for the muscular atrophy, but for the neuralgia itself. In sciatica also it is very useful. We are having the shoulder and arm of our patient massaged.

(v) Lastly, electricity must be mentioned. It is not a remedy that I have a very high opinion of in this disease; it can usually be cured without electricity. But if by ordinary means and massage the case does not progress, see what electricity can do. Faradism does harm; you must use galvanism, and whether the current goes up the nerves or down does not matter much. Physiological principles would suggest that it should go up them, and there is this advantage then, that it does not cause so much contraction of the muscles, and therefore much stronger currents can be used. But so far as the treatment of neuralgia is concerned clinical experience shows that it does not matter which way the current goes.

### Smallpox before Sydenham.

THE present outbreak of smallpox in London has directed a good deal of attention to a disease of which the younger generation has heard more than has seen.

Since the days of the founder of English medicine the recognition of the disease has been a matter of greater certainty, accurate descriptions of the epidemics exist, and are for the most part constantly quoted.

But before the power of clinical observation had been appreciated at its true value, before Sydenham began to look at his patients rather than his books, the history of smallpox in England is rendered obscure by the untrustworthiness of the observers.

It is to an Arabian historian that we are indebted for the first definite account of variola in Europe or its vicinity, who describes its appearance among the Abyssinian army at the siege of Mecca in what was known as the Elephant War of A.D. 569.

With the description is blended a short disquisition on the causation of the disease according to Arabic legend. "Thereupon came the birds from the sea in flocks, every one with three stones, in the claws two and in the beak one, and threw the stones upon them [*i.e.* Abrahah's army]. Wherever one of these stones struck, there arose an evil wound and pustules all over. At that time the smallpox first appeared."

Whether or not the present prevalence of smallpox among the Arabs dates from this war or not, there can be

no question that smallpox was introduced into the West through the Saracens, and the famous Dr. Freind, with whom Fielding and Hogarth spent many a pleasant evening in Little Britain, makes this remark: "The Saracens first brought in this distemper, and wherever their arms prevailed this spread itself with the same fury in Africa, in Europe, and throughout the greatest part of Asia."

Not only were the Saracens responsible for introducing the disease, but it was their pens which first described it. This together with measles was a peculiarly Arabian theme. It was from Rhazes rather than Galen that the observations and theories on smallpox passed into the English medical text-books. But though in literature we took over smallpox from the Arabians, it has been a subject of keen debate whether there had not been earlier experiences of the disease.

It has been claimed that an epidemic which was widely spread through the monasteries and elsewhere in the year 664 was nothing else than smallpox, yet from Beda's account there is certainly room for doubt on the point.

John Gaddesden, whose book 'Rosa Anglica' was a success in its day, early in the fourteenth century, though containing little that is not to be found in the Arabian Physicians, claims that he cured the "son of the most noble king of England," when suffering from variola, by the following treatment, which has been quoted with little enough reason as one of his originalities:—"I made everything about his bed red, and it is a good cure, and I cured him in the end without marks of smallpox;" but Gaddesden, though at one time a great name in medicine, was not reputed to be too scrupulous a practitioner, and the opportunity of diagnosing variola in the king's son may have tempted him beyond his clinical knowledge.

Dr. Cœc, in a clinical lecture given in 1896, mentioned an Anglo-Saxon book on medicine, called 'Lœce Boc,' written about A.D. 950, in which reference is made to a disease called pōc all or pustular disease, which, as he said, "may or may not be a name for variola." But in the 'Compendium Medicinæ' of Gilbertus Anglicus, written three hundred years later, or about, there is a chapter on variola and morbilli, which were, no doubt, our smallpox and measles.

In 1514 there is a letter extant describing the King of England as having had a fever, and that "the physicians were afraid it would turn to the pustules called variola, but he is now well again and rises from his bed." Although in this letter there is only the fear expressed that the illness might turn to smallpox, yet in the instructions sent by Henry VIII to Spinelly, English Ambassador in the Low Countries at the exact date, there is item to say that the English king has lately been visited by a malady "nommé la petite verolle." Four years later there is a definite account of an outbreak of "small pokkes and meizls" at Wallingford. From this time the use of the

word smallpox becomes fairly general, though the disease itself seems to have been not infrequently associated with or not distinguished from measles; and William Clowes, surgeon to St. Bartholomew's Hospital in 1575, translates the Latin "*variola*" by "measles;" and Phaer in 1553 goes further, and renders *variola* by measles and *morbilli* by smallpox.

The first record in English of a definite case of smallpox is found among the miscellaneous collections of Stowe, now in the Lambeth Library, where there is a narrative of the troubled conscience of Master Richard Allington, esquire, a gentleman who appears to have lent money at high interest. Believing himself to be dying on November 22nd, 1561, he summoned to his bedside the Master of the Rolls, two doctors of law, and two other lawyers. He began, "Maisters seinge that I muste nedes die, which I assure you I nevar thought wolde cum to passe by this deascasc, consyderinge it is but the small pokkes, I woulde therefore moste hertely desyre you in the reverence of God and for Christes passions sake to suffer me to speake untyll I be dede, that I may dyscharge my conscens," etc. He then explains that "no man had so especial tokens of God's singular grace, and so litele regarded them as I have done;" and goes on to mention particular acts of usury, and to offer restitution to the amount of some hundred pounds or more; "then he thought he should have died, but then broth being given unto him he revived again and fell to prayer, and gave himself wholly to quietness," and there the narrative ends; but from a further reference to him in Stowe's 'Survey of London' we learn that he did die in 1561, and that his widow was left well off.

There is no other evidence of the disease in England until it is mentioned in a letter written in 1591 to a member of Queen Elizabeth's Court, where it is said, "Hir Higness wold you should remove from that place where the small pokkes were, to take the fresh and clere ayre the better to purge ye from the infection."

In 1593 Kellwaye, writing the first systematic English essay on the disease, claims to speak from his own recent experiences, and gives an excellent account of smallpox, probably largely culled from the Arabian writers, but in addition goes a considerable way towards the separation of measles from smallpox, which was not fully effected in England until the following century. "What the measles or males are:—Many little pimples which are not to be seen, but only by feeling with the hand are to be perceived; they do not maturate as the pokkes doth do, nor assault the eyes," etc. And it was about ten years after Kellwaye's death that the classification of the deaths in London was begun by the Company of Parish Clerks, and it was in one of the first of their weekly and annual bills of mortality in 1629 that "Flox, smallpox, and measles" appears as one item,—the most probable explanation of "flox" being that it stands for confluent smallpox.

In the Report of the Medical Superintendent of the Hospital Ships, published this year, on the origin of the cases of smallpox treated during 1900, a woman is reported to have been admitted "whose husband had just died, it was supposed of measles, but there can be little doubt that the nature of his disease was hæmorrhagic smallpox,"—a gentle reminder that the difficulties and mistakes of the sixteenth century are still abroad in the twentieth.

About the end of the Elizabethan period and in the first years of the Stuarts, smallpox rises gradually to occupy a prominent place in the records of disease as a whole in England. Smallpox and measles may have been and probably were observed in England in the earlier part of the sixteenth century, but it is only after the beginning of the seventeenth century that they begin to figure with anything approaching frequency in domestic or public records. About 1631 a letter written by Dr. Donne, Dean of St. Paul's, shows a dread of the smallpox infection quite unlike anything we meet with in the former records. "At my return from Kent to my gate I found Kate had the pox: so I withdrew to Prickham and spent a fortnight there. And without coming home, when I could with some justice hope that it would spread no farther amongst them (as I humbly thank God it hath not, nor much disfigured her that had it), I went into Bedfordshire."

In the reigns of James I and Charles I cases of smallpox among the upper classes are occasionally mentioned in letters.

Credit for recording the earliest outbreak belongs to Aberdeen, in whose Kirk Sessions records for 1610, under the date of August 12th, occurs the entry, "There was at this time a great visitation of the young children with the plague of the pokks."

In 1612 there are various references to deaths from smallpox in London in rich houses.

In 1613 Lord Harrington, who is said in a letter of Dr. Donne's to be suffering from "the pox and measles mingled," died of smallpox (probably hæmorrhagic) on the Sunday before March 3rd, at which date also the Lady Burghley and two of her daughters were sick of the same disease. These two years probably represented an epidemic period.

In the year 1614 we learn from foreign writers that there was a pretty general epidemic spreading all over Europe, in which England was affected, yet there is no trace of this outbreak in our own records.

Another epidemic is known from letters to have occurred in 1621. "The smallpox brake out again in divers places, for all the last hard winter and cool summer, and hitherto we have had no sultry summer, nor warm winter, that might invite them. The Lord Dudley's eldest son is lately dead of them, and the young Lady Mordaunt is now sick." And on January 28th, 1623, "The speech that the smallpox

be very rife there [Newmarket] will not hinder his [James I's] journey."

Smallpox accompanied the typhus epidemic of 1623-4, as it has often done later, and the two together are recorded as "having taken away many of the good sort as well as mean people."

This record is the only one that mentions in any way the "mean people," but where the nobility suffered one can scarcely suppose the poorer classes were not affected to a far greater extent.

From the returns published by the Parish Clerks' Hall of the causes of death in London we find for the first eight years these figures for "flox, smallpox, and measles":

1629	...	...	72	1633	...	...	72
1630	...	...	40	1634	...	...	1354
1631	...	...	58	1635	...	...	293
1632	...	...	531	1636	...	...	127

The greatest epidemic, it will be seen, was in 1634. The figures for 1637 to 1646 are lost, but it is known from other sources that the autumn of 1641 was a terrible season both for smallpox and plague.

About the Restoration references to smallpox become more numerous. A letter of January, 1658, speaks of "much sickness in the town [London], especially fevers, agues, and smallpox." In 1660 Lord Anglesey is dead of smallpox, while Lord Oxford had a severe attack and recovered. On the 8th of September of the same year the Duke of Gloucester was diagnosed to have "a disease between the smallpox and the measles; he is now past danger of death for this bout, as the doctors say." Yet he died, on September 14th, on the tenth day of the disease, with remarkable evidences (verified by post-mortem) of internal hæmorrhage, having bled freely at the nose a few hours before death. The eruption had not "come out full and kindly" at the beginning, so that it was not the ordinary hæmorrhagic type.

Letters from a lady at Hambleton to her husband in London, May 26th, 1661, speak of smallpox raging in the place and in the house of her nearest neighbour, her own children having the whooping-cough.

All the indications, whether from letters, from poems or plays, or from statistics, point to the first two Stuart reigns as the period when smallpox first became an alarming disease in London among adults and in the upper class. Thus at Whitehall, in 1660, Charles II lost both a brother and a sister—the Duke of Gloucester and the Princess Mary of Orange.

Willis, one of the founders of the Royal Society, the friend and contemporary of Sydenham, was then at Oxford, and says in 1661 that smallpox began to rage severely before the summer solstice, adding that it was "a distemper rarely epidemical."

The bills of mortality for the years 1645-1666 are

extant, and show signs of epidemics in London in 1649, 1652, 1655, 1659, 1661, and 1664.

These figures bring us down to the time of Sydenham, the first accurate observer of smallpox in England, and beyond his date it is not intended to take this article.

Since the time of the greatest exponent of clinical medicine the records of smallpox are accurate and well known. Sydenham, of whom it is recorded that Boerhaave never spoke without doffing his hat, opened a fresh chapter in English medicine. And into this later chapter there is neither time nor space to dip. Our modern views of smallpox, at least in respect to diagnosis, are those of Sydenham, and there is but little that the physician of to-day could teach "the father of English medicine" concerning the recognition of the "variolæ."

### Four Cases of Meningitis, two of Tubercular Variety, the others of Anomalous Types.

By WILLIAM WYLLYS, M.R.C.S., L.R.C.P. Lond., L.S.A.

THE difficulty of making a correct prognosis in meningitis, and of determining what pathological process is at work in certain anomalous basal types, is my reason for publishing the account of four cases of this disease. Until reading a description by Dr. Still (see 'Journal of Pathology and Bacteriology,' May, 1898) of a form of basal meningitis due to a diplococcus, which sometimes recovers, I had believed that all but of my cases were of tubercular origin, described in text-books as invariably fatal, and was consequently very surprised when two of them recovered.

CASE 1.—E. M. L., a bright, intelligent little girl, aged 7 years, described as "too quick" at school, was placed under my care on account of headache, abdominal pain with diarrhoea, and loss of appetite, which had persisted for one week. Her pulse was 112, and temp. 99°, and a doughy tender mass could be felt in right iliac fossa, dull to percussion.

Her head was unusually large, especially in parietal and occipital regions. The child had complained of stiffness at back of neck, and occasional night sweats for three months. Sudden attacks of stomach-ache and sickness quite independent of food had occurred from time to time, also headache, which was stated to be loosened when stomach symptoms arose, and vice versa; irritation about anus and nose, causing patient to scratch these parts, gave rise to the idea of worms, but none were ever detected.

No history of injury to head could be elicited, neither were otitis, enlarged lymphatic glands, or joint lesion present.

The child had had measles, and lost one maternal aunt of phthisis pulmonalis.

Progress of case.—For first week symptoms pointed to either abdominal or cerebral mischief, but on the eighth day of treatment child became drowsy, and then comatose, with dilated pupils irresponsive to light. The abdomen was retracted, and incontinence of urine and faeces ensued. Tache cérébrale was demonstrated, and the respiration assumed the Cheyne-Stokes variety. Lungs and heart proved by physical signs to be normal. Two days later child was conscious again, could speak in a whisper in answer to questions, took nourishment well, and moved limbs naturally, though neck was rigid. Urine and faeces passed naturally; some pain in head was complained of.

Potassium bromide and iodide was given by the mouth, and sound sleep was procured. The pulse now was 150, and temp. 99°, and though no sickness or convulsion had occurred the case was looked upon as of cerebral origin. From the first appearance of coma an ice-cap was applied to scalp and hot bottles to feet, also Ung. Hydrarg. to nape of neck and to abdomen. Child remained

listless, drowsy, and exhausted, and became markedly emaciated. A week later unconsciousness occurred, with clonic spasms in arms and right leg; pulse running; skin very dry and harsh.

The next day paralysis of soft palate manifested itself with rigidity of limbs, wrist jerk, ankle clonus, and increased knee jerk on right side; there was also trismus. Rectal injections of milk, egg, brandy, opium, and potassium iodide were adopted, and patient rallied a little, but three days later a convulsion followed by left hemiplegia occurred, with Cheyne-Stokes breathing and retention of urine, and the child died on the thirtieth day of the disease.

Post-mortem.—The mesenteric glands were enlarged to size of filberts and were tubercular. Omentum and general peritoneum were studded with thousands of milky tubercles; small intestines matted together, especially in right iliac fossa, where they were adherent to abdominal wall and litum. The spleen showed deposits of tubercle on surface, the liver also, which was adherent to diaphragm. On removing vault of skull much clear cerebro-spinal fluid welled up; convolutions of brain were flattened, and a small patch of tubercular deposit was seen in meninges over right upper parietal convolutions. The blood-vessels at base were studded with tubercles, the sella turcica was occupied by an abscess containing thick green pus; optic nerves were swollen and perineurium congested; the pia mater of pons Varolii, medulla, and cord for two inches covered with grey tubercles. The brain weighed 52 oz.

The chief points of interest in this case "were the enormous weight of the brain (52 oz. in a child of only seven years), the selection of the tubercular process for the meninges, peritoneum, and mesenteric glands, the duration of the case—thirty days,—and the concurrence of tabes mesenterica with tubercular peritonitis.

CASE 2.—A boy aged eight years, was admitted to the Great Yarmouth Convalescent Home with strumous sinuses of right thigh and leg in June, 1897. The child was of the dull, dark-haired, strumous type, was deaf, and had a large head, especially posteriorly, a low, square forehead, the hair of scalp growing to within three quarters of an inch of eyebrows. He objected to bright light, and put his hand to right side of head constantly, saying that he had pain there. One night shortly after his admission I was summoned to his assistance on account of his having become unconscious, and found him with dilated pupils, the left especially so, irresponsive to light, conjugate deviation to right, and left hemiplegia, including facial paralysis. Temp. 99°; tongue furred in patches. Bowels costive. The child had vomited. Urine was passed naturally. Tache cérébrale was demonstrated.

Next morning the child took milk well; the breathing was quick at times and inclined to Cheyne-Stokes variety, but there was no cough. Pulse 110, temp. 99.4°. Choroidal tubercles were seen in fundus of right eye by ophthalmoscopic examination, and right optic disc appeared swollen; fundus of left eye normal.

Heart and lungs by physical signs appeared healthy. The urine contained an excess of phosphates but no albumen.

Three days later the child became comatose, with head thrown back and body drawn in; incontinence of urine and faeces ensued, and respiration became very shallow with occasional deep sighs. The following day the pulse rate became enormously accelerated, 180 per minute, temp. 101° in the morning, 102.8° in the evening; there was impaired resonance at apex of right lung with feeble entry of air to that lung, and a friction-rub in front of same.

The child died at 5.30 a.m. two days later. The temp. six hours before death was 104.6°, and a quarter of an hour before 106.4°.

The patient had been subject to suppurative otitis, and three maternal aunts and one uncle died of phthisis.

The short duration (one week) of this case, the intensity of symptoms and hyperpyrexia just before death, together with the hemiplegia, make this case of interest.

I regret that a post-mortem examination was not obtained, for although there is little doubt that tubercular meningitis was present the train of symptoms and signs pointed also to cerebral abscess.

CASE 3.—D. H., girl aged 6 years, received a blow on forehead from a small swing eight days before I saw her on August 21st, 1897, causing bruising of skin but no indication of fractured skull. She was much alarmed by this, and by nurse telling her weird stories; anorexia and rigors with frightened manner had persisted for four days. Her symptoms at first suggested typhoid fever, the tremors of hands resembling subulturn tendinum, and on investigation I found that there were clonic spasms of muscles of all her limbs and trunk. Her pulse was 150, and temp. 103.6° midday; her upper lip twitched, and voluntary movements were jerky, and the expression one of excitement and fear. The pupils were widely dilated. Child was thin and anæmic, but there was no history of cephalalgia

or vomiting. Her paternal grandfather had paralysis for years, and an aunt suffered from paralysis. The patient was ordered to bed, and next day found with knees drawn up and a hot dry skin; no rash was present and there was no sickness, though headache and no itching sensations were complained of.

For the next three days the pulse averaged 140 and temp. 102.5° in morning and 104.4° in evening, the bowels acted freely (motions offensive and of a greenish colour), and on fourth day the following signs and symptoms of meningitis were well marked—retraction of head, tache cérébrale, Cheyne-Stokes respiration, incoherent speech, insensibility of weight on top of head, and intolerance of light.

Two days later the child became delirious and noisy, taking nothing and sleeping badly, but on following day, presumably due to action of potass. bromide and iodide, became sleepy, yet when roused asked questions intelligently, and put out tongue when asked to do so.

By ophthalmoscope no choroidal tubercles or optic neuritis could be made out.

Urination and defecation were natural, and for the next few days patient slept well, took nourishment, and did not flex legs on abdomen; a period of delirium however again set in with incontinence of faeces and dilated pupils, which were irresponsive to light. But in two days' time the delirium had entirely disappeared, and an almost incredible improvement set in; the child's tongue became moist, she conversed freely, and was full of fun. This alternating condition of affairs went on for about twelve days.

On twenty-fourth day of disease aching pains in legs were complained of, and the pulse had risen to 160, temp. 104.4° in evening; knee-jerks were exaggerated, and next day light and noise were shunned; incontinence of urine occurred, and clonic spasms appeared in right arm; the day after these manifestations the temperature suddenly dropped to 97.8° at midday, the skin was cool and dry, and patient was very fretful.

From this date the case steadily improved, though the temperature was jerky for some time longer, and tremors of muscles were present, and tache cérébrale as late as thirty-second day of disease.

This case somewhat resembles Case 1 as to age, sex, duration, and marvelously sudden returns at times from coma to complete consciousness, with abatement of signs and symptoms of meningitis.

Was this due to a sudden wave of diminished pressure in cerebro-spinal fluid, consequent on lessened basic inflammation, or to the waning of bacterial influence from time to time? If to the former, I take it, the persistent use of ice to the shaved scalp with salomel and Potass. iodide taken internally and Unguent. Hydrarg. applied to nape of neck were helpful; if to bacterial intoxication, the variations in temperature might enlighten us as to the incubation period, toxic power, and rate of growth of the microbe of causation. While attending this child one was at first quite at a loss to say if typhoid fever was not answerable for the symptoms, later if the case was not cerebro-spinal meningitis, and finally tubercular meningitis, in which an exudation was produced in the meninges by the tubercle bacillus without the actual formation of tubercles or tubercular pus. To this view I leaned, but had I known at the time of the diplococcus described by Dr. Still I should certainly have considered the case one of intoxication by that germ.

The case was not one of epidemic cerebro-spinal meningitis, as no others were reported in the district, no skin eruptions occurred, nor were back pains or any joint lesions complained of.

CASE 4.—An infant, aged sixteen months, of strumous type, had been ailing six days with loose bowels, motions very offensive. When first seen pulse was 100, respiration panting; tetany and coma had set in with retracted head and strabismus; the feet were very cold, and there was incontinence of urine and faeces.

The following evening pulse 140, and same signs continuing, meningitis was looked upon as cause of illness and potass. bromide and iodide were administered. Coma with tetanic spasms of various muscles of limbs, trunk, and head, however, continued till third day, the pupils were dilated, and symptoms no doubt were aggravated by detention.

On fourth day child regained consciousness sufficiently to be able to take three quarters of a pint of milk, the pupils became semi-dilated, and at night she slept well, pulse still 140.

On fifth day child was quite conscious, and bowels were relieved by enema, and pulse had dropped to 120.

On sixth day took food and slept peacefully. The bromide and iodide were continued, and for a week nothing of moment occurred. On thirteenth day of treatment, however, patient again became very irritable, shunned light and sound, and developed thrush.

Hydrarg. cum Cret. and Syr. Ferri Iodidi were prescribed, and child

made steady progress and was marked off list as cured a fortnight later. An acute attack of bronchial catarrh unfortunately developed a week afterwards, but quickly subsided. Cod-liver oil and Syr. Ferri Phosph. Co. were then given for about a fortnight, when, signs of cerebral irritation commencing again, recourse was had to Hydr. cum Cret., Potass. Bromide and Iodide with satisfactory results.

This case is instructive in demonstrating a form of meningitis in infancy, which, of an anomalous type no doubt, occasionally occurs, and is now I believe classified as "non-tubercular post-basis meningitis in infants" (see 'Med.-Chir. Trans.,' 1897).

This child came of a phthisical stock, one of her brothers having died of tubercular meningitis in infancy, when the family lived in London. For convenience it may be well to quote an abstract, from the 'Medical and Surgical Review of Reviews,' of Dr. Still's article on this matter:

"It is generally admitted that there exists a simple meningitis in children apart from the tubercular disease, and from secondary infection from the ear or other centres of suppuration. In nine out of twelve cases of simple basis meningitis on which Dr. Still made post-mortems, he found in the exudation a special form of diplococcus, resembling in appearance the gonococcus.

"In two of the remaining cases the disease was of longer duration, so that the micro-organisms had probably disappeared owing to lapse of time. In a case operated upon in life the same organism was found, and cultures were obtained on agar and glycerine agar. Dr. Still regards it as probably a modification of the organism described by Weichselbaum as the 'Diplococcus intracellularis.'

"The possibility of recovery from the simple form of meningitis seems demonstrated by a case in which a child of eleven months suffered from the usual symptoms of basis meningitis, but improved greatly, only to die however of tubercular disease.

"At the post-mortem examination some thickening of the membranes and adhesion at the base were found, but no active meningitis. The case would previously have been regarded, in all probability, as tubercular meningitis owing to the generalised disease, but fortunately cultures from the cerebral ventricles had been made at a previous operation, and the diplococcus above described was found in practically pure culture."

### Death by Misadventure.

By C. S. HAWES, M.R.C.S., and R. T. WORTHINGTON, M.R.C.S.

THE following is a note on a case, the chief interest of which lies in the fact that a very clear account of an injury to the head, and the presence of a quite recent-looking hæmatoma on the forehead, led to a very complete error in diagnosis.

A. W., æt. 4, was brought up to the surgery on September 2nd, suffering from convulsions and with the following history.

The mother stated that she had gone out leaving the child perfectly well. When she returned half an hour later she found him lying on the bed "in strong convulsions." A little girl with whom the child had been left said that he had crawled under the bed to fetch a toy, and when coming out had fallen and struck his head against a knob on a chest of drawers. The girl then said that he at first cried out and then "went stiff all over and had a fit."

On admission to the surgery at 2.30 p.m. the child was nearly unconscious, but cried out once or twice; his pupils were widely dilated and fixed. The corneal reflex was present. He appeared to be in great pain. He almost immediately had a series of clonic convulsions, lasting for about ten minutes with very brief intervals between them. The convulsions were general, but at first much more marked on the left side than on the right; there was at this time no tonic stage. There was no deviation of the head or eyes. Within a quarter of an hour the convulsions became much more violent, and there was now a tonic stage of about thirty seconds' duration between each. During this tonic spasm there was extremely marked opisthotonos and great cyanosis.

When seen in the ward some twenty minutes after he was brought up he appeared to be utterly worn out by the violence of the convulsions, which were now much less violent; he was practically moribund.

There was now no opisthotonos, and it was remarked that the convulsions only came on when an attempt was made to rouse the child.

Both knee-jerks were absent, and there was no ankle-clonus. The pupils were still widely dilated and fixed; there was a very sluggish corneal reflex, but the child was unconscious. The spasms now consisted merely of a slight clonic twitching of the arms and legs. The temperature was 107.8°; pulse 140.

In the left frontal region was a large, apparently recent hæmatoma, and this, together with the history of the fall, led to the provisional diagnosis of laceration of the base of the brain, possibly by *contre-coup*, or possibly by direct violence.

The only treatment adopted was the administration of half a minim of croton oil.

The child gradually became more and more cyanosed, and died at 6 p.m. There was never urgent dyspnoea.

On the following morning the mother brought up a bottle of Patent Aloin Compound Tablets, which she stated had been full when she last saw it, and now contained only seven; when full it should contain fifty.

The girl above mentioned told the mother that the boy had said to her that he had found some sweets, and she saw him eat several of them.

The tablets contain: Ext. Belladonnæ, gr. ½  
Strych. Sulph., gr. ʒss  
Aloin, gr. ʒi.

A post-mortem examination revealed no evidence of the cause of death; the meningeal veins were extremely congested, and rigor mortis was very marked, especially in the legs.

At the inquest the jury returned a verdict of accidental death, holding that there was sufficient evidence to show that the child had died from strychnine poisoning. The stomach contents were therefore not analysed.

This note is written by the kind permission of Mr. D'Arcy Power.

### Note on a Case of Poisoning by *Datura Stramonium*.

By ELDON PRATT, M.D.LOND.

THE second of the "Clinical Puzzles" of Dr. J. L. Maxwell, in the JOURNAL for August, suggests to me a case of poisoning by *Datura stramonium*, which came under my notice four years ago.

The patient was a little girl, eight years old, who was brought to the surgery one evening. She was said to have eaten largely of some fruits, the like of which the mother produced from her pocket; I at once recognised the common thorn-apple (*Datura stramonium*). The child had vomited several times previous to admission. Her condition was certainly alarming; the face was flushed, and pupils were as widely dilated as possible and fixed; there was also apparently complete loss of vision, which seemed to be more than a mere blurring or mistiness. I cannot say that I paid any particular attention to this condition at the time, nor did I employ the ophthalmoscope. Pulse was rapid, but of fairly full volume; respirations were rather hurried. The child seemed quite helpless and unable to stand; two or three times she had curious attacks in which the limbs would be moved aimlessly about, the breath would be held for a few seconds, and then she would cry out, finally lying quiet again, the whole attack only lasting some eight or nine seconds. The skin was dry and warm.

For treatment the stomach was washed out thoroughly, brandy was administered, and one sixth of a grain of nitrate of pilocarpine injected hypodermically. There was nothing in the train of symptoms suggestive of coma or collapse. The next day the patient was much better, having had a fairly good night. There was still indistinctness of vision, although not the apparently complete amblyopia that existed when first seen. Good vision was subsequently rapidly regained, although the pupils were slow in returning to their normal state.

Although differing considerably from the case quoted by Dr. Maxwell, I think it helps to throw a sidelight on the fact that stramonium may cause temporary loss of vision; at the same time it does not seem quite likely that this would result without other severe toxic symptoms. I can only suggest that it might be possible for stramonium, taken continuously for some time, to produce such fundus changes as observed by Dr. Maxwell.

### A Family History.

By G. V. BULL, M.B., M.R.C.S.

THE following history of a family affected by congenital syphilis is interesting, I think, on account of the extensive affection, and especially for the way in which the disease has picked out the eyes, and in the case quoted the nervous system.

The mother gives no definite history of syphilitic lesions, but the history of her pregnancies, nine in number, is as follows:

1. Miscarriage.
2. Miscarriage.
3. Miscarriage.
4. Boy, "born blind," with snuffles and some affection of the nails, accompanied by ulceration. Died aged fifteen months.
5. Boy, born with snuffles; never able to walk; became blind at two years. Died aged three years.
6. Boy, "stillborn."
7. Girl (now under my care), aged five. She had snuffles at birth, but appears to have thrived till the age of three, when she was able to walk, though she was never very intelligent. Her sight has been failing for about one year, and she has lost her power of walking. Her present condition is as follows:—She has a vacant expression, and does not see well. Her head is below the average in size, and her mental development is very defective. She has occasional squint, and her pupils do not react to light. There are old posterior synechiae in the left eye, but no history of any acute eye affection. There are extensive deposits of pigment in both retine, and some old choroiditis. The left optic disc is pale and blurred, and the vessels small (?atrophy). There are numerous small vitreous opacities. There is no enlargement of the liver or spleen. She is unable to walk; her legs are rigid. The knee-jerks are exaggerated, and the toes give the extensor response.

She is evidently suffering from chronic cortical sclerosis, and the prognosis is gloomy. Mr. Gunn believes some good may be done to the eyes with antisyphilitic remedies, and she is therefore taking Hyd. cum Cret. and Pot. lod.

8. There are two younger children, aged two years and nine months respectively, who are apparently healthy, and have not had snuffles nor a rash. One may therefore hope that the virulence of the disease is now exhausted.

I have to thank Mr. W. T. Lister, who examined the eyes, for permission to use the note of the eye condition.

### Notes.

MR. D'ARCY POWER has resigned the post of Demonstrator of Practical Surgery, and has been appointed Demonstrator of Surgical Pathology.

MR. WARING has resigned the Demonstratorship of Operative Surgery, and has been appointed Joint Lecturer in Anatomy.

G. E. GASK, F.R.C.S., and R. H. URWICK, M.B., B.C., have been appointed Junior Demonstrators of Pathology.

J. E. G. CALVERLEY, M.B., B.S., has been appointed Companion of the Most Distinguished Order of St. Michael and St. George.

CONGRATULATIONS to A. H. Hogarth on receiving the Medal for Distinguished Conduct in the Field.

THE Decoration of the Royal Red Cross has been conferred upon Nurse Edith Pretty for her services to the Portland Hospital in South Africa.

WE have seen the first number of a new publication, the 'British Optical Journal,' and, while acknowledging the value which its articles possess for the practical optician, it is difficult not to comment unfavourably on the aspirations of the British Optical Association, whose annual general meeting is reported in this issue. The chairman at the meeting is quoted as suggesting that they should establish "refraction hospitals" in large centres, mentioning that at a large general eye hospital 7000 or 8000 cases of refractive error were dealt with each year. He put forward no scheme, but asked why public subscription for the maintenance of such medical institutions should be diverted to dealing with refractive errors.

In the name of all medical science from the time of Hippocrates till to-day why use the expression *diverted*? If this branch of ophthalmology is not a legitimate use of the funds subscribed for healing the sick, and maimed, and blind, what is it?

These skilled mechanics who hold the diploma of the Worshipful Company of Spectacle Makers are scarcely qualified to deal with the clinical aspects of *ametropia*. They do not appear to grasp the fact that the eye is something more than a mere optical instrument fitted with varying accuracy into the orbit.

Yet the fault is not entirely with them. We heard quite recently of a practitioner of some standing in a provincial town receiving a patient with a note from a local optician requesting that atropine might be put into the patient's eyes to enable him (the optician) to do a retinoscopy; and in this astounding proposal the doctor acquiesced, saying, when remonstrated with, "Well, I know nothing about eyes; he does."

It is impossible to picture the mental attitude of such a man, who could send a patient round to be repaired with the microscopes and barometers, and in similar fashion, for fear, no doubt, that if he recommended a specialist or other better informed practitioner he would lose this patient and perhaps others.

For all we know this practice may be wide-spread; if so, there is little cause for wonder at the suggestion of the British Optical Association that opticians should manage the eye hospitals.

It was a small typhoid patient who, thinking his diet was dependent on the strained finances of the Hospital, plaintively addressed his visiting physician, "Canst you spare us a meat pie, doctor?"

THE Sessional Opening Address of the Abernethian Society will be delivered on Thursday, October 10th, in the Anatomical Theatre, at 8 p.m., by Mr. Willett. His subject will be "A Historical Review of Changes in Procedure in the Treatment of Operation Wounds at St. Bartholomew's Hospital between 1857 and 1901."

THE next session will see the new régime in full swing at the meetings of the Abernethian Society; it will be interesting to discover whether the outcry raised last year in favour of smoking was voicing a real need.

THE south block will shortly be ready to receive patients in some of the upper wards.

The alterations will give universal satisfaction, the electric lighting will add greatly to the comfort of the patients and everybody who has to work in the wards. At the head of each bed a single incandescent light will project from the wall at a convenient height for illuminating the whole bed, while between every two beds is a wall-plug to which a moveable hand lamp can be connected, and used for the thousand and one purposes which the antiquated oil lamps now serve.

There will be three hanging lights from the ceiling of each half of the ward, the middle one of which can be let down and shaded for use at nights. No doubt other minor alterations have been made, such as a new larder in the kitchens; but compared with the important innovation of electricity these call for but little comment.

A TYPEWRITER is a useful thing, and, provided its health remain good, may prove quite a joy to its possessor. But if the placid working of its organs ceases, the usefulness exists no longer, and the joy is turned to sorrow. This unfortunate event recently happened to us; and wishful to know "the cause of this effect, or rather defect," as behoves a student of pathology, we indited the following brief note to the maker of the machine after the disease had been cured:

"DEAR SIR,—We should be glad if you would tell us the cause of the carriage of our typewriter having ceased to run smoothly, so that we may possibly prevent a similar thing happening in the future.

"Yours faithfully,  
"\_\_\_\_\_,"

Our prophylactic instincts met with the following reply:

"DEAR SIR,—Your favour of the 18th inst. has been awaiting the writer's attention.

It is very difficult to state a cause for the hanging of the carriage, and in any case there are so many adjustments about the carriage that you can hardly prevent it hanging.

"One cause is the fact that the balls of the guide-roller are apt in this climate to become slightly rusty, in which case they rub against each other and prevent the roller turning. We are curing this in a measure by sending out the guide-rollers with a slight touch of oil on the balls. You yourself could about every five or six weeks touch the edge of the guide-roller screw with a toothpick dipped in oil, and at the same time give a touch in a similar way to the screw in the centre of the spring box.

"Another cause of hanging is the rack-bar, the screw holes of which are slightly oval, gradually dropping down until the teeth press hard on the spring box.

"A third cause is due to the screws of the carriage release keys at either end working loose, and allowing the short steel carriage hook to work out of the square. This, of course, makes it jamb in the guide slot of the track rail. If these are looked to generally, and the ball track of the carriage polished, first with an oily rag, and then with a dry duster, there is little fear of the carriage sticking.

"Yours truly,  
"\_\_\_\_"

Despite the assurance conveyed in the last few words of this letter we do not look forward with much confidence to the application of preventive medicine to the diseases incident to our typewriter.

This opinion we took leave to express in a note written to thank the makers for their kind suggestions. We received the following in reply:

"DEAR SIR,—We do not think you will be troubled very much about the hanging of the carriage of your machine, but in addition to the causes mentioned in our letter, a still further cause is dealt with in the instruction book, page 12, under the paragraph 'Regulating the trip.'

"Trusting the machine is proving satisfactory,

"We remain,

"Yours truly,  
"\_\_\_\_"

### Amalgamated Clubs.

THE past year has been one of second bests in many departments, and a retrospect of the doings of the various teams may not come amiss, so that when the academic year begins in October men may see how athletics have prospered in the last twelve months, and where fresh effort is needed.

The Rugby XV came through the season with considerable success, just falling short when it came to meeting Guy's in the semi-final. There was a strange lack of consistency about the play during the season, possibly owing to the difficulty of getting men to play regularly. The forwards were the mainstay of the team, but there is room for some fast "outsides" in next year's fifteen.

The Association team have to confess to only qualified success. It is true the semi-final of the Inter-Hospital Cup was reached, but we tared no further, and Guy's won by 5 goals to 0, they in turn being beaten by St. Mary's in the final. At least five of last year's XI are not available, so that there will be room for new talent to help us into the final this year, and bring the Cup out of it.

Cricket during the summer was distinctly good. We had a strong batting side, that rarely failed to give a good account of itself. Burroughes and Nealon each scored two centuries. The most exciting match, perhaps, was that against London in the Inter-Hospital Cup ties, when our last wicket went in to get 22 runs and put on 43. We reached the final, but our lack of bowling was discovered and shown up.

The Athletic Club came off with flying colours and the Inter-Hospital shield, scoring 5 firsts and 2 seconds, with seven hospitals competing, yet despite our recent performances in the Inter-

Hospital competition, there is an extraordinary apathy with regard to this form of sport. We have usually been there or thereabouts of recent years when the trophy has been contested for, without any large section of the Hospital being aware of the fact.

The Boat Club revived itself to some purpose, and carried off both the senior and junior events. We may look forward with some confidence to further triumphs on the river, and we hope also that the day is not far distant when the Hospital will be represented at Henley.

The Swimming Club turned out a sound water polo team, and had three representatives playing regularly for the United Hospitals.

Hockey has "caught on" well since the Club was first started five years ago; the final of the Inter-Hospital ties (for which, by the way, a cup was presented two years ago, but by the rules of the Hockey Association never played for) was reached, but Bart's was beaten by the London Hospital with the small score of 2 goals to 1. It was not a good plan that was perforce resorted to last year, of alternating teams for nearly every match.

Last year we turned out a team for the Inter-Hospital Hare and Hounds for the first time for a good many years, and were only beaten by the narrow margin of two points. With the men who ran for us last year still in residence, there should be further news from this Club in the future.

The Lawn Tennis Club has not favoured us with very profuse accounts of its prowess in the tented field, but we see that the Inter-Hospital Cup, which has adorned the library table for the last three years, has betaken itself to other quarters.

Looking back, then, there is cause for congratulation, and at the same time some cause for regret. If we can go so near to success in several branches, why have we failed at the last? Where are the palmy days of Soccer, when Bart's figured in the final of the London Cup? For there is but little fear of fading distinctions in athletics too high. We see no tendency at present to undervalue academic successes, and we must never forget that the reputation of the Hospital, and the position which it occupies in the eyes of the world, are due to a judicious combination of science and sport.

### The Anatomical Department.

**D**URING the vacation extensive alterations have been made in the dissecting-rooms in order to devote more space to the teaching of applied anatomy and practical surgery, which hitherto has had no definite head-quarters. At the west end of the dissecting-room, in a line with the two gallery pillars, a glass screen has been set up extending the whole breadth of the room, cutting off about a quarter of its total length; this part is to be retained solely for the teaching of operative and practical surgery and applied anatomy, and a glass case, similar to that already in the Museum, will contain examples of all surgical instruments, arranged in order, and clearly labelled, so that they may be studied without being fingered too much.

In addition to the necessary tables for operating on the cadaver, there will be lay figures, to be used as dummies for bandaging, etc. Along the west wall will be two cases for instruments and apparatus. In the room where formerly the operative surgery classes were held, the anatomical demonstrations and tutorial classes will now be given by the demonstrators, instead of in any odd corner of the dissecting-room proper, as hitherto. The remainder of the room will continue to be used for dissection only.

The bone-room, which under the new arrangement will only be accessible through the operative surgery room, is to be turned into a splint and surgical appliance room, where in some new cases will be kept all forms of splints, trusses, etc., together with an artist's lay figure on which men may practise their application, and thus acquire a certain familiarity with their use before beginning surgery dressing, or if they are inclined to increase their own skill while engaged in dressing.

The general effect of these changes will be to give very much more space to the teaching of operative surgery, and the study of surgical appliances, which has hitherto suffered rather from want of material on which to practise; with lay figures on which men can

become dexterous in the use of bandages, splints, etc., a patient treated in the surgery at Bart's should be sent out in the future a model of neatness and good taste. There is little fear of the anatomical department being in any way cramped, as the whole floor of the present dissecting-room will be available for dissection. The number of tables will not be reduced, and the "grids" will be held in a much more suitable place, safe from any chance of being interrupted or disturbed by the goings and comings of others.

The whole measure is, we have no doubt, only temporary until the hospital extension is completed; but we think that Mr. Waring is to be congratulated on devising so effective and simple a scheme for economising and utilising to the best advantage the existing space in the rooms.

### Moonshine.

**B**EHIND my house there stands an oak,  
Nay, to be correct, a couple,  
Trunks so stout, and twigs so supple,  
It must puzzle stranger folk  
That trees so very stiff below  
Should wave their upper members so.

I call one Toby, Jack the other,  
And a thousand years—(or less)  
Will be about their age, I guess,  
And each is very like his brother.

Beneath them, when the grass is dry,  
(It seldom is!) I love to lie,  
And gazing supine at the swallows  
I've been known to muse as follows.

"To live the life of these old trees  
Must be, I fancy, very sweet,  
Contemptuous of cold and heat,  
And certain of one's bread and cheese."

"Unreckoned ages rack the earth,  
But still beside him at the end  
Each finds the same old silent friend  
That nodded to him at his birth."

(This stanza I sometimes repeat:  
An editor once called it neat.)

"The mad sou'wester bustles through  
And rips a dozen branches off,  
But Toby, million-armed, can scoff  
At whoso thieves a brace or two."

"And finds in life an added zest  
To see the swarms of human kind  
Grow bilious, bony, bald and blind,  
While he is swelling round the chest."

"Ah joy! To stand with vagrant roots  
Peregrinating out of sight,  
Nor cease, from dewy morn till night,  
A-sucking victuals through your boots!"

But when so far my musing's gone  
I fall to asking, "Is it wise  
To envy happiness that lies  
In endless aimless living on?"

"For dissolution comes at last,  
And even Jack must one day stop,  
And die down slowly from the top,  
Which must be worse than dying fast."

"T were hard to bear, I think, that we  
Should die progressive from the crown,  
And year by year be whittled down  
Unto the last extremity."

"To meet a solitary limb  
Perambulating here and there  
In quest of its aberrant pair,  
And sigh, 'There goes the last of Jim!'"

Oh no,  
I'd rather meet  
My doom, (where'er I go),  
Complete.

S. B.

### Old Students' Dinner.

**T**HE Annual Dinner of Old Students was held on Tuesday, October 1st, in the Great Hall. As had been anticipated, the attendance was exceptionally large, owing to the fact that this opportunity was being taken to present Sir Thomas Smith with his portrait, which has been painted by Mr. John Collier, R.A.

Mr. Walsham took the Chair, and after the usual excellent dinner had been dismissed, and the health of the King honoured, the Chairman proposed the toast of the "Hospital and School." After pointing out the continued prosperity which the Hospital enjoys, he went on to emphasize briefly the exceptional opportunity which now presented itself of acquiring sufficient space for the necessary expansion of the Hospital, and declared his conviction that if an appeal were made to the public, funds would not be lacking for the purchase of the whole site which will shortly be vacated by Christ's Hospital; he felt that there was little need for him to point out to a gathering of Bartholomew's men the urgent character of this question of expansion, which was acknowledged on all sides; yet at the same time he feared that the chance, if not accepted now, would never come within reach again.

Sir William Church, replying to this toast, expressed his satisfaction that the work of the Hospital, whether of a medical, surgical, or financial character, was aided by the constant presence of critics in our midst; saying that he often appreciated the naive criticism of some "green yet keen" student as an incentive.

Mr. Walsham then proceeded to the event of the evening, proposing the health of Sir Thomas Smith. No description, he said, was necessary of a man so well known, so looked up to, and so

admired by every generation of Bart's men. His career had been one long series of successes, whether as Demonstrator of Anatomy or Assistant Surgeon, teaching at out-patients with that marvellous fund of knowledge quickened by humour. Of his attainments as Surgeon there was even less need to speak, he would only remind those present that when Lord Tenter introduced antiseptic surgery to the world Sir Thomas Smith went to Edinburgh to acquaint himself at first hand with his methods, and was subsequently the first surgeon in London to practise them. The Chairman then offered to Sir Thomas Smith, in the name of the subscribers, the excellent portrait by Mr. John Collier, which he pointed out standing on an easel in a prominent position at the west end of the Hall.

Sir Thomas Smith in a short and humorous speech thanked the Chairman for the great honour which had been paid him, saying that he feared after listening to Mr. Walsham's remarks he might suffer from "swollen head," for which the science and art of surgery could provide no cure. He said that when first he heard of the proposal, some friends had told him that they must paint his portrait; however, he added, "I'm glad they didn't," but asked Mr. Collier to do it for them." After commenting on the likeness which some people saw in him to various famous men, not excluding a notorious criminal, Sir Thomas asked leave to depart from the authorised toast-list and propose the health of Mr. John Collier.

Mr. Collier, replying, spoke of the great pleasure he had derived from the sittings for the picture, and of the entertaining interviews he had enjoyed with Sir Thomas Smith.

Subsequently Mr. Bowlby proposed the Toast of the Navy, Army, and Reserve Forces, to which Sir Henry Norbury, Director General of the Navy Medical Department, and Colonel Hendley, I.M.S., replied for their respective branches. Sir Lauder Brunton in a short but entertaining speech gave the health of the visitors, coupled with the names of Professor Clifford Allbutt and Professor Rucker, likening them to the two great lights in physic and physics, Harvey and Galileo, who, being contemporaries, had each profited by the researches of the other till they achieved those two marvellous scientific discoveries, the circulation of the blood and the theory of the pendulum.

The two professors then replied in turn on behalf of the visitors. The Dinner closed with expressions of gratitude from the Chairman to the Secretary, Dr. Herringham, on whose shoulders the burden of arranging the details of the evening had fallen, who, however, was wisely responsible for the success of the evening.

An adjournment was then made to the Library for coffee, and the guests gradually dispersed, after a most enjoyable evening.

## Boarding House Geometry.

### DEFINITIONS AND AXIOMS.

1. All boarding houses are the same boarding house.
2. Boarders in the same boarding house and on the same flat are equal to one another.
3. A single room is that which has no parts or magnitude.
4. The landlady of a boarding house is a parallelogram—that is, an oblong angular figure which cannot be described, but which is equal to anything.
5. A wrangle is the disinclination of two boarders to each other, that meet together but are on the same flat.
6. All the other rooms being taken, a single room is said to be a double room.

### POSTULATES AND PREPOSITIONS.

1. A pie may be produced any number of times.
2. The landlady may be reduced to her lowest terms by a series of propositions.
3. A bee line may be made from any boarding house to any other boarding house.
4. The clothes of a boarding house bed, though produced ever so far both ways, will not meet.
5. Any two meals at a boarding house are together less than one square meal.
6. If a line be drawn from the opposite ends of a boarding house, passing through all the rooms in turn, then the stove pipe which warms the boarders will lie within that line.
7. On the same bill, and on the same side of it, there shall be two charges for the same thing.

8. If there be two boarders on the same flat, and the amount of side of the one be equal to the amount of side of the other, each to each, and the wrangle between one boarder and landlady be equal to the wrangle between the landlady and the other, then shall the weekly bills of the two boarders be equal also each to each. For if not, let one bill be the greater—then the other bill is less than it might have been—which is absurd.—From the 'Alleyrian.'

## Volunteer Medical Staff Corps.

THE members of No. 3 Company (St. Bartholomew's and St. Thomas's Hospitals) of the Volunteer Medical Staff Corps will hold their Fourth Annual Ball at the Empress Rooms, Royal Palace Hotel, Kensington, on Friday, November 15th. The dance was originally fixed to take place in February last, but was postponed on account of the death of Her late Majesty Queen Victoria.

The function will, no doubt, be a great success, owing to the support which is invariably given by the staff of this Hospital. The tickets are limited to 350, and these were all applied for in February. The present officers of the company are:

Surgeon-Captain G. Sims Woodhead, M.D.  
" H. Work Dodd, F.R.C.S.  
" W. E. Miles, F.R.C.S.

And the Honorary Chaplain,  
The Rev. Sir Borrardale Savory, Bart., M.A.

Tickets and every information may be obtained from members of the Committee and the

Hon. Secretaries, { S. E. CRAWFORD, St. Bartholomew's Hospital.  
ERNEST A. MAY, Elmhurst, Elm Road, East Sheen, S.W.

## "S.T.H.A.O."

THE eighteenth Annual General Meeting of the Dramatic Club was held on October 4th, the President, Mr. W. H. Cross, in the chair.

The following officers were elected:  
Stage Manager.—Mr. A. R. Tweedie.  
Assistant Stage Manager.—Mr. H. S. Ward.  
Acting Manager.—Mr. R. J. Waugh.  
Mr. V. C. Upton was elected auditor.

The meeting then adjourned. Those anxious to become members are reminded that it is desirable to do so as soon after joining the Hospital as possible, in order that, by forming an early acquaintance with the Club and its management, they may be ready to take up their position as its officers when called upon in their turn to do so.

It is regrettable to notice how many men delay joining the Club till their fourth or fifth year, becoming interested only to find either that work is too pressing to allow of their sacrificing as much time as they could wish to things dramatic, or that the burdens of qualification compel them to seek "fresh fields and pastures new."

## Reviews.

DISEASES OF THE THYROID GLAND AND THEIR SURGICAL TREATMENT. By JAMES BERRY, B.S.Lond., F.R.C.S., Surgeon to the Royal Free Hospital, and Lecturer on Surgery at the London School of Medicine for Women, Surgeon to the Alexandra Hospital for Hip Disease. (London: J. & A. Churchill. 1901. Pp. 367, 121 illustrations. Price 14s.)

This book is based upon the Essay for which Mr. Berry was awarded the Jacksonian prize of the Royal College of

Surgeons in the year 1886, the Hunterian lectures delivered by him in 1891, and his experience in this branch of surgery for the past fourteen years. The Jacksonian Essay in its original form was never published, owing to the fact that the author felt "he had had so little personal experience of thyroid surgery, that it was undesirable to commit his observations to print." Since then he has enjoyed unusual facilities for the study of this part of surgical practice, and much of what was written in the original essay has been entirely rewritten by the light of further experience. The result of this delay in publication has been a distinct gain to medical literature, since the volume under consideration can be truthfully said to be a sound exposition of the practice of the surgery of the thyroid gland, according to the personal experience of Mr. Berry and those other surgeons, such as Kocher, who have devoted a considerable amount of energy to the advancement of the treatment of diseases of this gland.

The book is divided into twenty two chapters. The first of these comprises a succinct account of the anatomy of the gland in question, which in the main corresponds with that given in the text-books of anatomy. Kocher's description of the arrangement of the thyroid veins is followed, in preference to that usually adopted by English anatomists. The arrangements of the lymphatic vessels which take the lymph from the gland to the lymphatic glands in the neighbourhood, are not very clear from the description; a condition of affairs which might have been improved by the insertion of a diagram.

The physiology of the gland is not considered in a separate chapter, but references are made to it in various portions of the book.

Endemic goitre is discussed at full length, and in conclusion Mr. Berry states, "There can be no doubt that climatic and atmospheric conditions have little or no share in the production of goitre. That there exists some definite relation between endemic goitre and some poison in the soil upon which it is found is tolerably clear, and there can be no doubt that in the vast majority of cases drinking water is the vehicle by means of which that poison obtains access to the body. Such water is usually, if not always, derived from calcareous soils, but it is probable that the goitre-producing poison is not a salt of lime or magnesia. It has not yet been satisfactorily shown that any salt of iron is the essential constituent. The same may be said of micro-organisms."

The chapter on exophthalmic goitre is of interest. After a very detailed account of the different forms of operation which have been performed for this disease, the author says: "It seems to me that it may be reasonably doubted whether surgical treatment is not on the whole worse than useless. With regard to ligature of the thyroid vessels it still seems to me doubtful whether this proceeding is followed by cure sufficiently often to justify its

performance. There seems to me no doubt that if any of the operations are undertaken by the surgeon, that they should be performed in most cases without general anaesthesia, and that they should be performed with as little disturbance as possible to the surrounding parts."

In connection with malignant disease it is asserted that the operation for removal of malignant disease of the thyroid gland, unless performed at a very early stage of the disease, is attended by a high mortality from the operation itself. In the majority of cases the only treatment that can be adopted is but palliative, and consists chiefly in relieving the patient from dyspnoea, dysphagia, and pain.

The terminal portion of the work comprises the consideration of the treatment of the various forms of non-malignant disease, and the results which have been obtained. Mr. Berry gives a table of the last one hundred cases which have been operated upon by himself. Out of these ninety-nine recovered, and one terminated fatally.

We strongly recommend the perusal of this work to all students of surgery who wish to keep their knowledge up to date as regards the subjects treated.

SURGICAL APPLIED ANATOMY. By SIR FREDERICK TREVES, K.C.V.O., C.B., F.R.C.S., with the assistance of ARTHUR KEITH, M.D., F.R.C.S. (New and revised edition, price 9s. Cassell and Co.)

The fourth edition of this widely read handbook does not stand in need of further praise to ensure its popularity. The previous editions have made the book known to every generation of students since its first appearance, and its excellence is acknowledged on all sides.

The present edition has been slightly enlarged by additions to the letterpress, which serve to keep it up to date with the steady advance of modern surgery, and some new illustrations have been added, or in some instances substituted for the old ones.

CLINICAL PATHOLOGY AND PRACTICAL MORBID HISTOLOGY. By T. STRANGEWAYS PIGG, M.A. Second Edition. (Strangeways and Sons. London. Price 5s. net.)

We have received a second edition of this excellent volume. Though addressed to students, and designed in the main to enlighten the beginner, there is little in it that will not be also of the greatest value to any one who is not constantly engaged in pathological work.

The main object of the author is to explain the technique of his subject, and in this he has succeeded admirably; few books give this particular information in so concise or intelligible a manner. The illustrations are excellent and add greatly to the value of the book, for which, as a whole, we have nothing but praise.

"GOLDEN RULES" SERIES. Nos. IX, X, XI, price 1s. each. John Wight, Bristol.

The three numbers we have received of this series deal respectively with "Aural and Nasal Practice," "Hygiene," and "Diseases of Children"; it is possible that is not a waste of time publishing this series, but we only make the suggestion tentatively.



## Calendar.

October, 1901.

- Oct. 1.—Dr. Hensley and Mr. Butlin's duty.  
 " 4.—Sir Lauder Brunton and Mr. Walsham's duty.  
 " 8.—Sir William Church and Mr. Willett's duty.  
 " 9.—Mr. Langton's Clinical Lecture.  
 " 10.—Abernethian Society. Opening Sessional Address by Mr. Willett.  
 " 11.—Sir William Church's Clinical Lecture.  
 Dr. Gee and Mr. Langton's duty.  
 " 12.—R.F.C. v. London Irish, at Herne Hill.  
 A.F.C. v. Ewell, at Ewell.  
 Hockey Club, Southfield, at Southfield.  
 " 15.—Sir Dyce Duckworth and Mr. Marsh's duty.  
 " 16.—Mr. Langton's Clinical Lecture.  
 " 17.—Abernethian Society. E. Talbot, M.B., "Modern Treatment of Pulmonary Tuberculosis."  
 " 18.—Dr. Hensley and Mr. Butlin's duty.  
 Dr. Gee's Clinical Lecture.  
 " 19.—R.F.C. v. Park House, at Winchmore Hill.  
 A.F.C. v. Reigate, at Reigate.  
 Hockey Club v. West Herts, at Watford.  
 " 22.—Sir Lauder Brunton and Mr. Walsham's duty.  
 " 23.—Mr. Langton's Clinical Lecture.  
 A.F.C. v. R.M.A., at Woolwich.  
 " 24.—Abernethian Society. Clinical Evening.  
 " 25.—Sir William Church and Mr. Willett's duty.  
 Sir Dyce Duckworth's Clinical Lecture.  
 " 26.—R.F.C. v. Marlborough Nomads, at Surbiton.  
 A.F.C. v. R.I.E.C., at Cooper's Hill.  
 Hockey Club, Norwood, at Beckenham.  
 " 29.—Dr. Gee and Mr. Langton's duty.  
 " 30.—Mr. Willett's Clinical Lecture.  
 Hockey Club, Blackheath School, at Blackheath.

## Appointments.

ATLEE, W. H., M.B., B.C.(Cantab), M.R.C.S., L.R.C.P., appointed Senior House Physician to the Metropolitan Hospital.

BOYLE, H. E. G., M.R.C.S., L.R.C.P., appointed Casualty Officer to the Royal Infirmary, Bristol.

BRANSON, W. P. S., M.B., B.C.(Cantab), M.R.C.S., L.R.C.P., appointed Casualty Officer to the Children's Hospital, Shadwell.

MACKAY, E. C., M.R.C.S., L.R.C.P., appointed Junior House Surgeon and Anesthetist to the Royal Infirmary, Bristol.

MACLAREN, N., B.C.(Cantab), M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Metropolitan Hospital.

MAXWELL, J. L., M.D.(Lond.), appointed Surgeon to H.B.M. Consul, South Formosa.

NIXON, J. A., M.B., B.C.(Cantab), appointed Senior House Surgeon to the Metropolitan Hospital.

WHITAKER, L. E., M.R.C.S., L.R.C.P., appointed Civil Surgeon to His Majesty's South African Field Force.

WHITE, F. N., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed Junior House Physician to the Metropolitan Hospital.

WILLETT, J. A., M.D., B.Ch.(Oxon), M.R.C.S., L.R.C.P., appointed Junior Resident Medical Officer to Queen Charlotte's Lying-in Hospital.

## New Addresses.

- BLAGDEN, J. J., Homeleigh, Yelverton, S. Devon.  
 BREWERTON, E. W., 45, Weymouth Street, Portland Place, W.  
 CALVERLEY, ERNEST J. G., Claremont House, Cheriton Road, Folkestone.  
 DALE, C. B., Winterslow, 115, Bristol Road, Edgbaston.  
 DICKSON, A. W., Stannary House, Stainland, near Halifax (not near Darlington) as previously inserted.  
 FARMER, W. H., 6, Lymington Road, West Hampstead.  
 FEGAN, R. A., Templecrow, Westcombe Park, S.E.  
 HAIG, T. R., 13, Lyndhurst Crescent, Auburn, Melbourne, Australia.  
 WARING, H. J., 37, Wimpole Street, W.

## Birth.

SMITH.—On September 10th, at High Down, Hindhead, the wife of Gilbert Smith, F.R.C.S., of a daughter.

## Marriages.

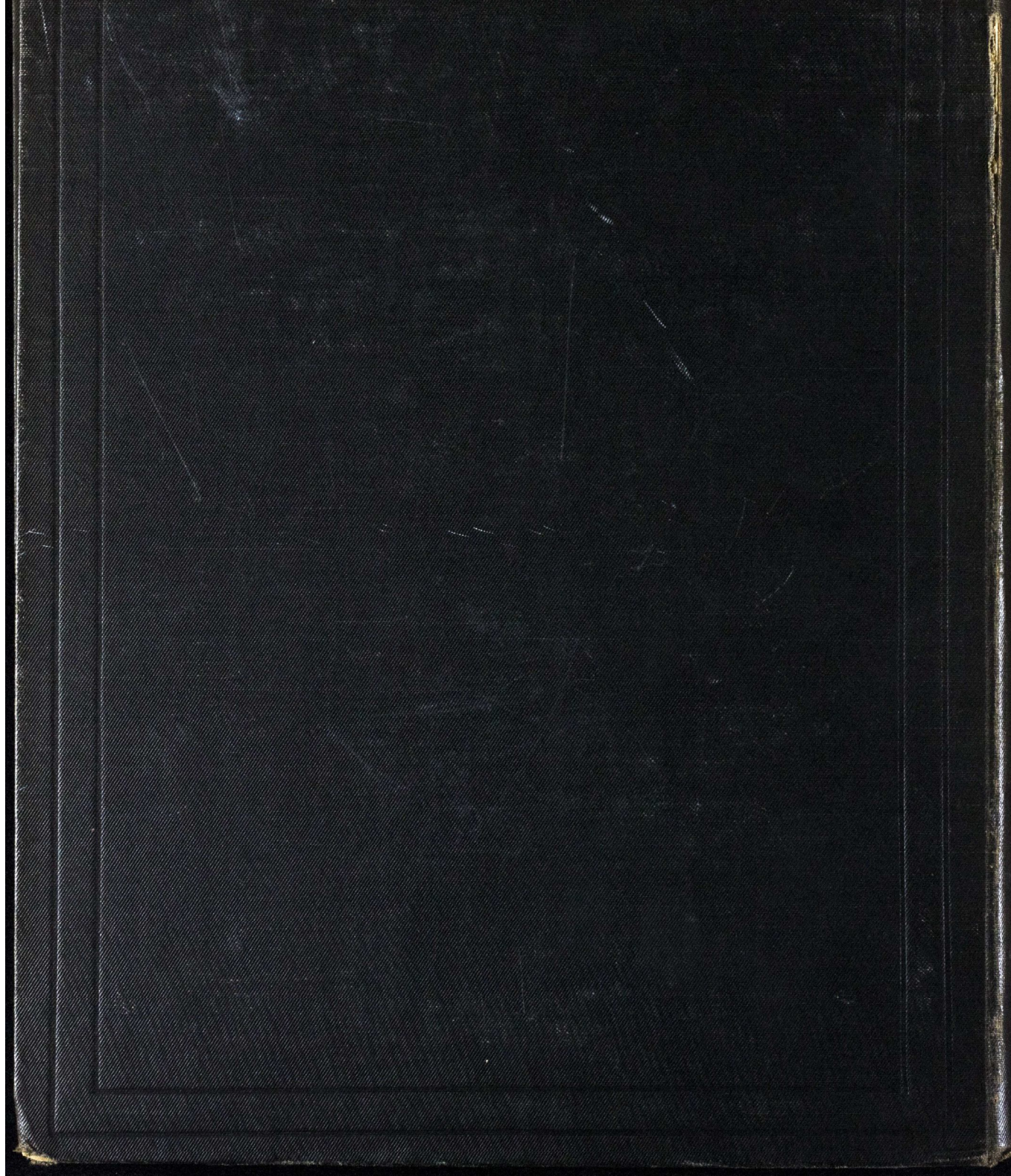
CALVERLEY—DOUËT.—On July 27th, at St. John's, Lewisham, Kent, Joseph Ernest Goodfellow Calverley, M.B., B.S., of Claremont House, Folkestone, and late of the Portland Hospital, South Africa, to Evelyn, daughter of E. Douët, Esq., of St. John's.

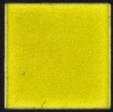
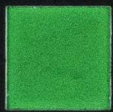
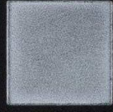
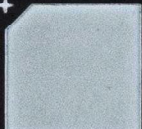
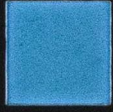
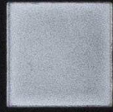
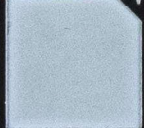
CORBEN—OCKENDEN.—On September 17th, at St. George's, Hanover Square, by the Rev. E. J. Haynes, M.A., Charles Corben, M.R.C.S., etc., of Caldicot, Chepstow, to Annie Bulmer, widow of the late R. J. Ockenden, Esq., and third daughter of the late Major John Godson, Madras Staff Corps.

CRACE—CALVERT—ADAMS.—On September 11th, at Clapham Congregational Church, by Rev. J. C. Thompson, of Heathfield, George Alfred Crace-Calvert, M.B., M.R.C.S., Llanbedr Hall, Ruthin, to Ellen Marguerite Adams, elder daughter of Francis Adams, Shamrock Lodge, Park Hill, Clapham, S.W.

DICKSON—TIDMARSH.—On September 18th, at Holy Trinity, East Finchley, by the Rev. William Breton, M.A., of St. Patrick's Church, Hove, Avery Wynn Dickson, M.R.C.S., of Stainland, Yorks, second son of the late Lieut.-Col. Dickson, R.A., to Eveline Amy, daughter of the late Rev. William Tidmarsh, B.A., of Putney.

GUTCH—METCALFE.—On August 27th, at St. Michael's Church, Sutton, Wansford, Northants, John Gutch, M.D.(Cantab), of Ipswich, eldest son of the late John James Gutch, of Holgate Lodge, York, to Dorothy Emily, second daughter of the late Frank Metcalfe, of Mote House, Wisbech, and of Mrs. A. Metcalfe, Manor House, Sutton.



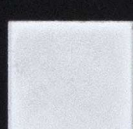
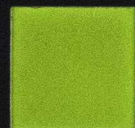
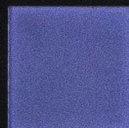
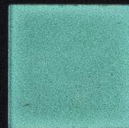


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