St. Bartholomew's Hospital Journal.

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

VOL. XXIII.—No. 9.] JUNE 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Fri., June	2.	—Dr. Calvert and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Hartley.
Mon., ,,	5.	—Exam. for Matriculation (London) begins.
Tues., ,,	6.	—Dr. Morley Fletcher on duty.
Wed., ,,	7.	—Clinical Lecture (Surgery), Mr. D'Arcy Power. Applications for Lawrence Scholarship to be sent in.
Fri., ,,	9.	—Oxford Easter Term ends. Clinical Lecture (Medicine), Dr. Horder. Dr. Drysdale and Mr. Bailey on duty.
Sat., ,,	10.	—Oxford Trinity Term begins.
Sun., ,,	11.	—Whit Sunday.
Mon., ,,	12.	—First and Second Exams. for M.B.(Camb.) begin.
Tues., ,,	13.	—Dr. Tooth on duty.
Wed., ,,	14.	—Clinical Lecture (Surgery), Mr. Waring.
Fri., ,,	16.	—First and Second Exams. for M.B.(Oxford) begin. Dr. Garrod and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine) Dr. Horder.
Tues., ,,	20.	—Dr. Calvert on duty.
Wed., ,,	21.	—Clinical Lecture (Surgery), Mr. Bailey.
Fri., ,,	23.	—Dr. Morley Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Calvert.
Sat., ,,	24.	—Cambridge Easter Term ends.
Mon. ,,	26.	—D.P.H. Conjoint Exam. begins.
Tues., ,,	27.	—Dr. Drysdale on duty.
Wed., ,,	28.	—Clinical Lecture (Surgery), Mr. Bailey.
Thur., ,,	29.	—Exam. for Shuter Scholarship begins. Second Exam. Conjoint Board begins.
Fri., ,,	30.	—Dr. Tooth and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Hartley.
Mon. July	3.	—Second Exam. for Med. degrees (London), Part II, begins. M.D. and M.S. Exams. (London) begin. Second Exam. of Soc. of Apothecaries begins.
Tues., ,,	4.	—Final Exam. Conjoint Board (Medicine) begins. Dr. Garrod on duty.
Wed., ,,	5.	—First Exam. of Soc. of Apothecaries begins.
Thur., ,,	6.	—Final Exam. Conjoint Board (Midwifery) begins.
Fri., ,,	7.	—Final Exam. Conjoint Board (Surgery) begins. Dr. Calvert and Mr. Bailey on duty.

EDITORIAL NOTES.

IT is with the greatest regret that we have to announce the death of Captain R. K. Macgregor, R.A.M.C. He was accidentally killed in France on April 28th. Educated in the first place at Edinburgh and University College School, London, he studied medicine at this Hospital, and was qualified in 1911. He went to France with the first Expeditionary Force, being promoted Captain at the end of his first year of service. Our deepest sympathy is extended to his parents, Dr. and Mrs. Macgregor, in their bereavement.

* * *

Since our last issue Major Rawling and Lieut. Mackenzie Wallis have left the Hospital for an unnamed destination. They, together with Captain Stanley, have been appointed to the 34th General Hospital (the Welsh Hospital). We understand that another old Bart.'s man, Lieut. J. S. Burns, has also been appointed to that unit.

Major Gask has also left for the front "somewhere in France."

We wish them all luck during their absence.

* * *

Our heartiest congratulations are extended to Mr. D'Arcy Power, who has been elected President of the Medical Society of London for the Session commencing October, 1916.

* * *

It is with great pleasure that we record that Colonel A. E. Garrod has had the Order of Companion of St. Michael and St. George conferred upon him for distinguished service in the Field.

* * *

We congratulate the following recipients of Birthday Honours:

Privy Councillor. Dr. Christopher Addison.

C.I.E., Major F. N. White, I.M.S.

C.B. (Military Division). Additional Members. Surg.-General W. G. A. Bedford, C.M.G., M.B., Col. O. R. A. Julian, R.A.M.C.

C.M.G. Additional members. Col. C. E. Harrison, C.V.O., M.B., F.R.C.S., Army Medical Service (T.F.); Lt.-Col. L. Humphry, R.A.M.C.

Lt.-Col. E. P. Sewell, R.A.M.C., has been awarded the Distinguished Service Order.

* * *

Sir C. P. Lukis, K.C.S.I., K.H.S., V.D., Director-General of the Indian M.S., has been appointed Commissioner for the St. John Ambulance Brigade Overseas, within the Empire of India.

* * *

It is interesting to note that three sons of members of the staff have received the Military Cross, viz.: John Dennison Eccles, Lt., Queen Victoria's Rifles, son of Major McAdam Eccles; D'Arcy Power, Captain, R.A.M.C., S.R., son of Lt.-Col. D'Arcy Power; L. R. Shore, Captain, R.A.M.C., son of Dr. T. W. Shore.

Other old Bartholomew's men on whom the same decoration has just been bestowed are: Capt. G. E. Dyas, R.A.M.C.; Capt. T. J. C. Evans, I.M.S., Tempy. Capt. A. J. Kendrew, R.A.M.C.; Surg.-Capt. W. T. Rowe, S. Notts Hussars; and Lt. (now Capt.) C. J. Stocker, I.M.S.

* * *

A lecture on "Amputations and Artificial Limbs" will be given by Mr. Elmslie on Tuesday, June 13th, at 12.45 p.m. in the Medical and Surgical Theatre. The subject is a most important one at the present time, and will, no doubt, interest any old St. Bartholomew's men who are holding medico-military appointments and who are not too far from London to be present.

CHRISTMAS DAY IN THE DESERT.

THERE was trouble on the Western Frontier of Egypt, and the "Western Frontier Force" had been rapidly collected and had partially assembled at Mersa Matruh—a port on the Mediterranean 180 miles west of Alexandria—in order to cope with the trouble. Thus it was that I found myself in December, 1915, at a spot I had never heard of before, engaged in operations against an enemy whose name was unknown to me until a few weeks previously. My humble *rôle* in the subsequent performance was that of A.D.M.S. of the force. After a little indecisive skirmishing our aeroplanes located the enemy, some 3000 to 4000 strong, camped in a nullah or wadi about seven miles west of Matruh, and our G.O.C. chose Christmas Day as a suitable occasion to do a little "strafing," on the principle, I suppose, of "the better the day, the better the deed." This decision, however, touched our mess in a tender spot, as we had with some difficulty and commendable foresight collected a plum pudding, some mince pies and a bottle of port; and with these we had planned to celebrate Christmas in the usual way. The situation was met by the simple expedient of keeping Christmas on the previous day, the proposal of waiting till the day after being instantly vetoed.

An early start being ordered, we all turned in soon after dinner; but not to sleep, as snipers kept firing into the camp and our pickets wasted a good many rounds of ammunition on them. At last all was quiet, and it seemed only a few minutes afterwards that the bustle and noise of the stirring camp warned one that it was time to get up. A plunge into the cold and dark, a hasty breakfast, and then a brisk canter to the head of the column, where we fell into our places behind the General and started off on the march. It was a curious effect in the moonlight—the long column of men, horses and guns moving silently in the sand, with ambulances and transport wagons in the rear, and a column of camels shuffling along without a sound. The presence of so many men and animals close to one in the dim light, coupled with the uncanny silence, gave a weird effect of unreality, almost as if the whole thing were a cinema show.

We had marched about three miles when my attention was attracted by a sharp exclamation, "What's that on the right?" A small spot of light, apparently about 600 yards ahead and to the right, suddenly appeared and rapidly grew bigger, and it was soon obvious that the enemy had spotted us and lighted a beacon fire to warn their friends of our approach. The column was halted, and a squadron of cavalry sent out to see if they could round up the lighters of the fire. The latter fired a few shots and ran off, and were lost in the darkness.

Soon after this a faint light began to show in the east, and in due course the sun rose in Oriental splendour, and our greatcoats and mufflers were discarded.

About 8 a.m. a shrapnel from the enemy brought us the greetings of the season, and some heavy explosions on our right directed our attention to the sea, where we could just see a naval ship firing her big guns, the shells of which were kicking up a great dust on the hills a mile ahead.

Our guns now came into action, and the infantry deployed. The guns did good work, as they put their fourth shot right into the enemy's gun emplacement and silenced the gun for the rest of the day. The enemy had other guns, but for some reason or other they never brought them into action.

The infantry now advanced steadily over an open plain against the enemy's position in the hills, and casualties began to trickle back to the Field Ambulance. These were dressed, fed, and sent back to Matruh by motor ambulance all day long, so that the wounded were in a comfortable bed within two hours of being wounded, in many cases. In the meantime the cavalry had done a wide turning movement, and had arrived in rear of the enemy. This made matters too hot for them, and they retired into their wadi—Wadi Majid as it was called—in the caves and recesses of which they kept up a scattered fight for the rest of the day, being gradually driven down the Wadi towards the sea. It was intended that the cavalry should completely surround them and block their exit to the west; and if they had

succeeded in doing this, all the leaders of the enemy's forces would have been captured and the campaign brought to a close prematurely. Unfortunately they were unable to complete the ring, and the leaders escaped.

In the late afternoon the enemy were in full flight, and we were in possession of their camp, where a large quantity of ammunition and supplies were captured.

It only remained for us to collect our forces and return to Matruh, as scarcity of water and transport rendered it impossible for us to follow up our victory.

By 9 p.m. all the troops had returned to the rendezvous, but one regiment reported that some of their men had not come in, so we had to sit in the cold and dark waiting for them with some anxiety, as they might easily get cut off in the dark. Large fires of brushwood were lit as a guide, and at 10 p.m. a man found his way into camp and said he had been sent in to say that there was a party of his regiment, including the medical officer, and some wounded and prisoners left out some miles away. A relief party was instantly collected, and disappeared into the darkness with the man as a guide. They were fortunate enough to find them, and brought them in at 2 a.m.

Unable to sleep for the cold, we were glad when at 4 a.m. it was decided to march home, and we eventually arrived at our camp at 7 a.m., after twenty-six hours' absence, tired but pleased with our first effort.

The humour of the situation did not come out till afterwards when we captured Gafar, their Commander-in-Chief, who confessed that he thought all British soldiers got drunk on Christmas Day, and so he had planned to make an attack on our camp on Christmas night. Our attack rather spoilt his plans for our Christmas entertainment.

Our casualties were light. The most interesting case was a Yeomanry officer who was hit in the abdomen close to the umbilicus. There was no wound of exit. He had fæcal vomiting on the second day, and his life was despaired of. But to our astonishment it stopped, and he made an uninterrupted recovery.

No. 15 General Hospital,
Alexandria.
April 15th, 1916.

E. P. SEWELL,
Lt.-Col. R.A.M.C.

SOME OPHTHALMIC LESSONS OF THE WAR.*

By WALTER H. JESSOP, M.B., F.R.C.S.Eng.

THE *first* subject I wish to consider is *sympathetic ophthalmitis*, or rather its absence, as far as I know, amongst the wounded treated by our surgeons at the Front.

* Abstract of Presidential Address delivered at the Congress of the Ophthalmological Society of the United Kingdom on Thursday, May 4th, 1916.

To Colonel Lister and the other ophthalmic surgeons at the Front has been primarily due the prevention of sympathetic ophthalmitis. I have corresponded with practically all our colleagues at the military hospitals, and have not as yet heard of one case of sympathetic ophthalmitis, and the war has been on for 21 months. The number of eyes wounded has been very great, and especially the number of those very seriously damaged by shrapnel—the cases so aptly described by Colonel Lister as split "like the corolla of a very much faded flower."

In the American Civil War 41 cases of sympathetic ophthalmitis occurred in 254 cases of destruction of the eyeball—that is, 16·14 per cent.

The German official returns for the Franco-German War gave the very high percentage of 55·6 in all cases of injury to the eyeball. The number of sympathetic ophthalmitis cases was 97, and 52 of these occurred within one year of the injury; the seriously damaged eyeballs gave the highest percentage of sympathetic trouble.

The extraordinary immunity from sympathetic ophthalmitis must be due to care in diagnosis, careful primary operative treatment, and especially the early and complete removal of all portions of the globe in much smashed eyeballs.

The *second* subject is *papillœdema* following gunshot injuries to the vault of the skull. In this war wounds of the head by bullets, etc., have been more frequently met with than in any previous war.

In cases of fracture of the vault * a large percentage (about 60 per cent.) showed signs of papillœdema, and the opportunities given of following the course of the papillœdema strengthens the view that the old chapters on optic neuritis, choked disc, neuro-retinitis will have to be quite rewritten.

The ophthalmoscopic changes were usually slight swelling of the papilla, sometimes amounting to 1 or 2 D.; the edges of the discs were blurred and indistinct, often there was a narrow yellowish-white ring round the optic disc, and the changes were, as a rule, within the equator and near the papilla—in fact, these changes were an œdema of the papilla and the retina. In some cases there were soft woolly looking plaques, and in a few cases there was extreme swelling of the optic discs with hæmorrhages, plaques, etc. These conditions were associated with increased intracranial pressure, and on relief of the intracranial pressure the œdema disappeared in a short time, and in most cases no after changes are to be seen by the ophthalmoscope. This coincides with the findings of Paton and Holmes, who, in cases of cerebral tumours, have demonstrated that the swelling of the papillæ is an œdema and not an inflammation primarily, and that such cases usually called optic neuritis ought to be named papillœdema.

The *third* subject is the condition of the retina in *trench nephritis*, which is a disease that has affected numerous

* *The Ophthalmoscope*, vol. xiii, p. 593.

soldiers in this war, and of which the actual cause has not been found.

These cases of trench nephritis, according to Capt. W. Langdon Brown,* are examples of acute nephritis, and are epidemic, infective, and due to some specific infection resembling, but not actually, the organism of scarlet fever.

I have had the opportunity of examining the eyes of about 150 cases of trench nephritis; the ophthalmoscopic examinations have been made with the pupils dilated by homatropine and cocaine, the source of illumination being a candle (Priestley-Smith) lamp, or ordinary daylight.

Some of these cases have also been mentioned by Mr. Foster Moore, and have been referred to by him in an interesting paper in the *Lancet*, December 19th, 1915, p. 1348.

I wish first to refer to my last consecutive forty-five cases, as I have examined these more carefully for slight signs of œdema; my first cases were looked at chiefly for gross changes as hæmorrhages, white plaques, detachments, etc. In twenty-one of the cases (46·6 per cent.) there were signs of œdema of the retina; in many these signs in a few days cleared up, so that the percentage of cases of œdema is probably much higher. In three cases with œdema of the retina there were other changes—one had a single, superficial, flame-shaped hæmorrhage, one commencing retinitis with plaques, and one the signs ordinarily described as albuminuric retinitis. Of this last case, a man æt. 27, the great interest is that all the ordinary changes up to resolution took place in twelve weeks from the onset of general symptoms. The œdema of the retina commencing three weeks after the symptoms of dyspnœa, œdema of legs, etc., was succeeded by white, soft-looking plaques, hæmorrhages, macular star. In eight weeks the only changes to be seen were small, hard-looking, white spots at the maculæ, in twelve weeks the left-eye changes had quite disappeared, and there were in the right eye six small, very bright white spots near the macula. In sixteen weeks there was nothing to be seen in either eye. This case was undoubtedly one of acute nephritis, and all the signs of soft, woolly-looking, white plaques, and hard-looking white spots were present. One was able, as Charcot said, to use the ophthalmoscope to investigate living pathological anatomy, practically as a microscope on the living tissues.

In none of these forty-five cases were there any signs of pathological changes in the retinal vessels; this fact is true in nearly every other case I have observed. Curiously, in only three cases was there a previous history of scarlet fever, and in these three cases the ophthalmoscopic appearances were normal. The constant signs in every case were albumin in the urine and œdema in the extremities or face. The blood-pressure varied very greatly in different cases. The detachments of the retina mentioned by Mr. Foster Moore due to œdema and sometimes a solid or nearly solid œdema, all cleared up. During the clearing-up stage there were white plaques, hard white spots, hæmorrhages, etc. All these symptoms help to confirm the diagnosis of trench nephritis being toxæmic.

For a long time it has been known that pregnant women are liable to manifestations of toxæmia,* and Mr. Fisher has published a very interesting paper on "The Retinitis of Pregnancy." As he said, and I thoroughly agree with him, it might have been headed Toxæmic Retinitis of Pregnancy.

Some years ago I had written a paper for our Society on tuberculous retinitis, which was never published. The main points are effusions, limited or diffuse, in the retina followed during the process of resolution by a retinitis with white plaques which cleared up completely. This clearing up, according to Rochon-Duvigneaud and Mawas, is due to the action of phagocytes, and one can almost by the ophthalmoscope see the process—the periphery of the plaques becoming ragged-looking. Since then I have had cases where no signs of tubercle could be found, which must have been due to septic infection.

In our *Transactions*, vol. xxv, p. 102, is the drawing of an analogous case recorded by Mr. R. E. Bickerton. I am showing another case at this present meeting. These cases of toxæmic retinitis in trench nephritis, gravidic retinitis, and tubercle are characterised by an œdema, sometimes amounting to a definite detachment, diffuse or limited, of the retina, the presence of white soft woolly plaques, hard white spots or dots, hæmorrhages, but not primary affection of the blood-vessels.

We find the same conditions in the so-called diabetic and albuminuric retinitis. Are not all these generic terms misleading, or rather unscientific? It has long been known that exactly the same signs as, some writers say, are pathognomonic of albuminuric retinitis are found without any signs of kidney mischief and without any albumin in the urine. Is there a typical albuminuric retinitis? Are there any definite ophthalmoscopic signs which would establish an absolute definite diagnosis by themselves alone? These questions cannot be answered in the affirmative.

I would suggest that there is at first an œdema of the retina in all these cases, which may be toxic in origin. Like the œdema of the eyelids, extremities, etc., in nephritis, the cause is not proven, and therefore there is no reason to suppose it may not be toxic.

In many cases the presence of fibroblasts produces the solid œdema, the white plaques, etc.

As to the definite toxin, this may vary in different diseases, but the signs of the toxæmic retinitis or retinœdema are practically the same.

It is an interesting lesson this war has taught us that in the last two of my subjects the presence of œdema either as papillœdema or retinœdema is so often to be found, and

* The *Lancet*, February 19th, 1916, p. 391.

* *Proc. Roy. Soc. Med.*, vol. viii, p. 127.

may be so fugitive. It will be still more interesting if these conditions lead to a clearer and more correct understanding of the so-called albuminuric retinitis.

TWO CASES OF DISLOCATION OF CERVICAL VERTEBRÆ, WITHOUT DEATH.

By Major W. McADAM ECCLES, M.S., F.R.C.S., and D. S. PRACY, M.R.C.S., L.R.C.P.

Traumatic Dislocation of the Fourth Cervical Vertebra Forwards and Downwards on the Fifth.

M. B—, a woman, æt. 43, fell downstairs on November 28th, 1915, whereby her head struck the ground, and her

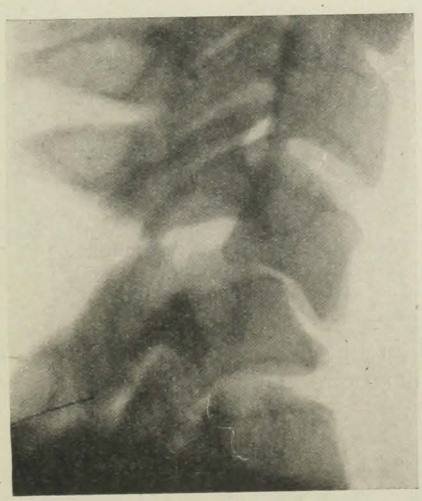

FIG. 1.—LATERAL VIEW. THE FOURTH CERVICAL BODY HAS SLIPPED FORWARD ON THE FIFTH.

neck was bent forcibly forwards. She was unconscious for two hours. A large hæmatoma developed on the occiput and extended on to the cervical region. On the advice of her medical man, Dr. M. Ryan, she was kept in bed for a month. On getting about after this she found stiffness in the neck with considerable pain on attempting to move the cervical spine, the pain running down into both upper extremities, and being particularly marked in the digital area of both ulnar nerves.

There was no evidence of any distinct muscular paralysis, whether of upper limbs, diaphragm, trunk, or lower limbs, although the intrinsic muscles of the left hand supplied by the ulnar nerve did not contract voluntarily so strongly as those of the right side. The sphincters were quite normal.

On examination no irregularity of the cervical vertebræ could be detected, but there appeared to be somewhat of a hollow between the fourth and fifth cervical spinous processes.

The patient was only able to flex her neck slightly in the antero-posterior and lateral directions, some fixation being apparent about the level of the fourth vertebra.

X-ray examination showed a very significant deformity. In the lateral view (see Fig. 1) it will be observed that the head with the four upper cervical vertebræ has slipped forwards and downwards. The body of the fourth vertebra is lying so that its lower lipped edge is almost in contact with the lower lipped edge of the centrum of the fifth vertebra. Further, there is clearly discernible a marked gap between the spinous processes of the fourth and fifth cervical vertebræ, that portion of the ligamentum nuchæ attached to these spines having probably given way.

In the antero-posterior view there will be seen (see Fig. 2) a separation between the transverse processes of the fourth and fifth vertebræ, the cervical spine at this level

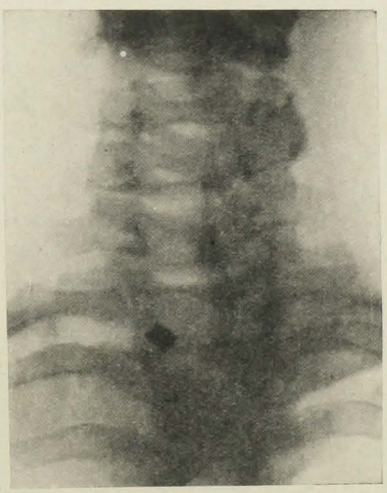

FIG. 2.—ANTERO-POSTERIOR VIEW. THE FOURTH CERVICAL VERTEBRA IS SOMEWHAT SEPARATED ON THE RIGHT SIDE FROM THE FIFTH.

having been forcibly flexed to the left. There is no evidence of any fracture.

The case is of interest from the following points:

(1) The level of the lesion.

(2) The fewness of the symptoms.

(3) The fact of recovery of the patient.

The most common level for a dislocation or a fracture dislocation of the cervical spine is between the fifth and sixth vertebræ. At this level, even if the spinal cord is injured, respiration is carried on through the action of the diaphragm, the phrenic nerves remaining intact. But when the level is higher than this death is almost certain.

That there should have been so marked a dislocation forwards of the body of the fourth cervical vertebra without greater involvement of the cord is remarkable. Where dislocation occurs as the result of disease there is time for the cord to accommodate itself to its altered relations, but where the displacement is the result of traumatism

the sudden compression of the cord causes, as a rule, most marked symptoms. In this case the absence of muscular paralysis is of great interest, for it shows that the cord must have almost entirely escaped injury. The fact that the patient, after a prolonged rest in the recumbent position, has recovered with only a slight anæsthesia in the ulnar distribution is highly gratifying.

It was somewhat difficult to decide whether any manipulative treatment should be adopted. None was carried out because, the symptoms being slight, it was felt that they might be increased by any attempt to reduce the dislocation.

It was also difficult to determine when the patient might be allowed to move her head and neck without fear of any likelihood of further slipping of the vertebræ; but after four months it was considered safe, and so far no untoward result has followed. W. McA. E.

Dislocation Forwards of Atlas on Axis due to Disease.

This case was under the care of Mr. Bailey, who has kindly given permission for the following notes to be published.

L. W—, a schoolboy, æt. 14, noticed, in the middle of December, 1915, that he had a dull diffuse pain in the suboccipital region and a certain amount of stiffness on attempting to move his head. These symptoms increased in severity gradually until his admission to hospital on March 15th, 1916. At that time he also complained of a swelling on the right side of his neck, but this, on examination, proved to be the transverse processes of his cervical vertebræ made prominent by the position of the head.

On admission the condition was as follows:

The patient was an unhealthy-looking boy, and kept his head thrown slightly backwards with the chin rotated to the left. This position he apparently maintained by spasm of the deep muscles of the neck, probably the left superior and inferior obliques. The more superficial muscles were not contracted.

Movements.—Patient was able to rotate his head a little, but could not painlessly bring his chin to the middle line. Nodding movements were much more easily executed. Patient had no pain on percussing the top of his head, but the spines of the upper cervical vertebræ were distinctly tender.

No enlarged glands were palpable in the neck or elsewhere. No abnormality was discovered in the chest or abdomen. Temperature, pulse, and respirations were normal.

Nervous system.—Knee-jerks present but not easily elicited. Sphincters natural. Sensations: No objective abnormality, but patient said that occasionally his right hand felt numb, and he would be unable to hold a pen to write a letter.

Several skiagrams were taken at different times without any discovery of disease in the vertebræ, but one taken on March 27th showed that the atlas and cranium were dislocated forwards on the axis and other cervical vertebræ. The transverse ligament of the atlas had apparently given way and the odontoid process was nearly touching the posterior arch of the atlas. Probably the position appears a little exaggerated in the skiagram, as the view is not absolutely a lateral one.

This case is of interest:

(1) As a contrast to Major Eccles' case.

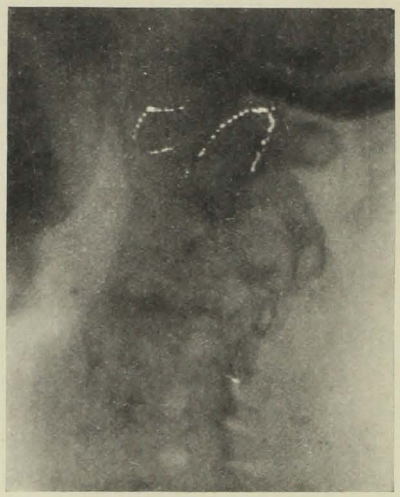

FIG. 3.—L. W—. DOTS OUTLINE ANTERIOR ARCH OF ATLAS AND ODONTOID PROCESS OF AXIS. IT WILL BE SEEN THAT THE ATLAS IS DISLOCATED FORWARD ON AXIS.

(2) As illustrating his remarks regarding the absence of symptoms of compression of the cord in dislocation due to disease. In this case nearly total compression of the cord must have occurred. D. S. P.

"HOUSE SURGEON ON DUTY."

IT is well known that the life of a house surgeon is one full of experience, but how many can realise what it is to be house surgeon on duty unless they have at some time fulfilled that onerous task? The experience gained during these three or four days, as the case may be, is great and far reaching. H.S./D. for once in his life seems to hold an important position; he has a bell of his own which reminds the whole hospital of his existence; he has, or thinks he has, numerous people at his beck and call—porters, dressers, nurses, the steward, whom he can worry endlessly when he has no beds of his own, and, last but not least, his chief who sleeps at his mercy. H.S./D., though a prisoner in the hospital, comes much in contact with the outside world.

H.S./D., if he is lucky during the night and does not have to get up in the small hours of the morning, commences his day's work at 10.0 a.m. by starting his morning round in

the wards. Of course, after one bad night's rest, when he still feels a little sleepy, he notices that one or two sisters are a little irritable; after two bad nights, sisters and perhaps "blue belts" are not so pleasing as they might be; but after three or four bad nights, when H.S./D. feels just alive, sisters, nurses, dressers, porters and everyone else do something wrong and try to hinder instead of helping him. He appears to be the only person who can do anything right.

It is not until duty is well over and his weary mind has been rested that he begins to realise how tired and irritable he has been. He then sees how sisters, dressers, nurses, and porters have helped him, and he begins to wonder why he does not appear to have made for himself many enemies. Fortunately, tired looks win a lot of sympathy.

When the round is finished an appetite for lunch begins to make itself felt. Unfortunately, one's board has to be altered before this can be satisfied, and one usually finds messages there such as "Case in S——," "Wanted in ——," or "Please ring up ——." The main importance of such messages to H.S./D. is that they disturb his lunch.

H.S./D. is seldom allowed to have his meals in peace. To sit down and prepare for a meal in comfort is a sure signal for someone to worry him; especially is this the case at dinner when he is also on duty in the Surgery. I well remember a busy Sunday on duty when I had tried hard to find time for tea. I had just sat down and commenced tea when a porter came and said that a doctor who knew my father very well wanted to see me about a patient he had sent in. As he was waiting at the top of the steps leading to the dining hall, I hurriedly finished my tea and went to see him. I had never seen him before, and I am certain that my father had never seen him. The conclusion I came to was that the old gentleman thought that a house surgeon was the son of the surgeon.

After lunch, the surgeon arrives and either "goes round" or operates. From what I have already said, it is obvious that, especially towards the end of duty, he appears to make his round very long and to talk at great length about every case to his following, who also appear for some reason to be abnormally interested and to encourage him to continue his words of wisdom. It never dawns on H.S./D. when he is very tired and has more work to do than appears possible, that duty cases are very interesting and provide much scope for learning. All H.S./D. thinks about is getting the round over as soon as possible.

At 6.0 p.m. the surgical receiving officers go off duty, and H.S./D. is on duty both for in-patients and out-patients in addition to being on duty for a variable number of house surgeons, including throat and ophthalmic house surgeons, who may go out. This is the time at which H.S./D. commences to be really busy. There is always plenty of work to be done in the wards, and though the night dresser tries hard to keep the surgery under control, yet casualties have a wonderful way of making one very late for dinner. It is impossible to give any accurate idea of the work of H.S./D. from now onwards. His work is most variable and so cannot be described except at great length. One evening on duty I did not see a single patient after dinner, on other occasions I have never ceased seeing patients till well into the small hours of the morning.

As a rule, a patient comes to the hospital in the evening who requires an operation. As soon as the case has been examined the surgeon is telephoned for, and while he is on his way to hospital the theatre has to be got ready, an anæsthetist has to be provided, porters have to be told what ward to take the patient to and what time the patient has to be in the theatre, and the sister of the ward has to be told that a patient is being sent in. What an offence it is if the sister is not told! Most sisters seem quite satisfied if they are told one minute or less before the arrival of the patient in their ward.

When the surgery is full of patients to be seen before the arrival of the surgeon, it is very easy to forget to tell someone that an in-patient has arrived. The result will obviously be disastrous. Either the patient will not arrive at the theatre, or there will be no anæsthetist, or the theatre will not be ready, as the case may be.

The surgeon, when he arrives, seems to have a wonderful gift for asking his H.S. questions that he cannot answer. He may know all the surgeon expects about the history and physical signs, but such questions as "What is the name of the doctor who sent this case up?" "When did he first see a doctor?" "What is the age or occupation of the patient?" are very puzzling. I could never remember to ask them all, and if I managed to ask the doctor's name I was sure to forget to ask the age of the patient.

When everything is ready for the operation to commence the H.S. longs to hear his chief say, "You do this." There is much more to be learned by doing one operation than by watching several. A surgeon who, when he is tired after a day's work, is content to help his H.S. who will take much longer to do the operation than if he did it himself, is doing his H.S. a very good turn, and one that will not be forgotten. When the operation is over and when the surgery is cleared, H.S./D., accompanied by his night dresser, does his night round and then retires to the "middle room" in the Surgery, where he and his dresser find cocoa always ready. This is about the only time when H.S./D. can expect to be left unmolested. Cocoa in peace after rushing about all day is greatly appreciated. The time has arrived when there is an opportunity of easing one's mind by giving vent to the most important scandal of the day, and for soothing one's temper before going to bed if it has been unduly irritated.

The time at which H.S./D. retires to bed is variable. He can never retire before midnight, and he often does not get to bed till after 2.0 a.m. When he does get to bed his sleep is an uncertainty. Some nights he will be unmolested; others he will be worried one or more times. Much

depends on having a competent night dresser, and much depends on the porter. Nothing is more annoying than to have a porter come and wake one up by mistake for someone else, and perhaps offering you a district clerk's letter, but I suppose there are very few who have not had this experience. H.S./D. may be called to patients in the wards or to cases in the Surgery, especially police cases. The latter seem frequently to come about 8.0 a.m.—a very bad time if he has got to bed late, because by the time the patient has been seen it is too late to return to bed, and an hour's sleep has been lost.

So much for the life of H.S./D. I will now pass to those he comes in contact with. Humour and pathos are often closely associated, especially in the Surgery. Some patients have trivial maladies, some, especially when of military age, have no maladies, and some are struggling hard between life and death. The former usually come direct to the Surgery; the latter are, as a rule, sent up by some doctor outside, unless the case is an accident. Trivial maladies are usually the ones which are apt to test the temper of H.S./D. Some of these patients say immediately that there is nothing much the matter and do not try to over-estimate their maladies. They are easily dealt with and soon satisfied. The chief offenders are talkative mothers who bring small children and who try to exaggerate to a most wonderful degree. A mother one day brought a small boy who frequently had mild attacks of facial erysipelas. When asked what she had brought the boy up for, she started at a terrific rate explaining what a good boy he was, how well he did at school, and how well he behaved to his brothers and sisters. After a lot of persuasion she got more to the point and finished emphasizing the degree of swelling by saying that "Yesterday his little face was as flat as yourn." Some patients regard it as an unpardonable offence if they are not attended to immediately. Returning from the operating theatre one evening, I looked into the female duty box to find an excited young lady on a police stretcher—she had been knocked down by a bus but did not appear to be badly hurt. She gave me the following greeting: "Now, young man, when am I going to be attended to?" A more polite patient was first attended to, and then we returned to this excitable nuisance. She said she had hurt her arm and back. Her arm she allowed to be examined, but she flatly refused to have her back looked at. The police demanded the nature of her injuries; they were, of course, not forthcoming. They decided to telephone to their station to ascertain what was to be done in such cases. In the meanwhile the patient was aided off the stretcher by two confederates and limped out of the hospital. When the police returned from the telephone they ran out into the street carrying their stretcher, in search of their *protégé*, much to the amusement of the waiting patients.

I gently rebuked a patient one day for coming very late when she could have come earlier. Her reply was somewhat embarrassing: "Go on; I don't want to see you, I want the head doctor"—the night dresser.

Duty brings one in contact with an interesting type of patient—one who finds it profitable to meet with a trivial so-called accident. His disease is "Kompensitis." He is, as a rule, easily found out, but sometimes one cannot be absolutely certain that he is a fraud when seen for the first time. Write on his paper "Kompensitis," and when he comes again whoever sees him will be on guard, and will often be able to save the hospital the expense of skiagrams and medicine. When he returns he is sure to ask for a certificate.

Having made a few remarks about patients with trivial maladies, I will say a few words about those who are seriously ill. These patients, as I have already said, are usually sent up by a doctor from outside under whose care they have been, some for a short time and some for a considerable time. How many doctors realise that they can lighten the arduous duties of H.S./D. to a very great extent by sending a letter with the patient, giving an account of the symptoms while under observation, and stating what conclusions they have arrived at? What a help it is if a doctor takes the trouble to telephone to the hospital and ask if he may send a patient up, and to give an account of his patient. What a help it is if a doctor sends a patient up at a reasonable hour, and does not wait until he sees him late at night and then in despair sends him up. Unfortunately a large majority of medical practitioners do not seem to consider the hospital and those working there in the least. They seem to regard the hospital as an institution where they can put the responsibility for their patients on other shoulders at any time they like. I wish it were possible to publish prints of some of the documents sent by doctors with patients. Some patients are sent without anything at all, others bring a doctor's card or a dirty, ragged piece of paper with some such remark on as the following: "Admit this patient suffering from appendicitis," "This is to certify that —— is suffering from acute appendicitis and should be operated on immediately," "Hip disease ? ? lameness, etc." (a case of cerebro-spinal fever), "Speech defective, slight nasal obstruction, bad teeth, eczema of scalp."

I will give one example of what thoughtlessness on the part of the doctor may lead to. One night, at 11.45 p.m., a porter fetched me and said there was someone in the Surgery who wanted to see me about a patient. When I arrived in the Surgery I found two women there who had been sent by a doctor to know if we would take a patient in who was very ill. I asked if the doctor had said what he thought was the matter with the patient, or if he thought she needed an operation. I was at once informed that the doctor had told me all about the patient in a letter he had sent by them. The letter consisted of the doctor's card, on the back of which was written: "Abdominal symptoms, etc., etc." I was told that it would take them an hour to

get home and an hour to bring the patient up. That is to say, that the patient would arrive at 2 a.m. Supposing, now, that an operation had been necessary. The patient would first have to be examined, then the surgeon would have to be telephoned for and brought to hospital—not an easy thing when there are no taxis or 'buses—then an anæsthetist would have to be fetched out of bed, and finally the night dresser would be kept up, to say nothing of the troubles the nursing-staff would be put to. The operation could not commence till 3 a.m. at the earliest and would be over, roughly, at about 4 a.m. The surgeon would then have to go home before returning to bed. How much sleep would any of us get, all of whom have to face another hard day's work? Fortunately, the case was not a severe one. The doctor, however, thought an operation would be necessary and could easily have sent the case up earlier, for she had been under his care for some few days. He was on the telephone, and could have saved time by telephoning instead of sending up relatives who knew nothing about the case.

From time to time one hears complaints that house-surgeons do not let the practitioner know the progress of their patients. Is it surprising?

Patients occasionally send or bring humorous letters to hospital. The following is one brought by a Russian Pole, who knew very little English: "Dear Sir, I am asking you to cure my hand, because when I take anything up into my hand, it falls down. I have not got any strength in my hand and it hurts me very much. Will you please oblige me by curing it as soon as you can? My head also hurts me very much and will you please give me a medicine to it."

The next was one sent from Scotland: "Dear sir I should Esteem it a favour if you could oblige me by sending to the above address a few doses of medicine or a plaster for my back I get such pain round the Kidneys and feel tired when I rise in the Mornings has if I had never seen Bed I think it Must be a laxy liver I am a Married Woman age 3–6 years my husband is a Disabled Soldier we are here has he is doing light Work for goverment and there is not a shop yet in this village or a doctor for a good few miles of course we will get all in good time has they are Building fast I have been a out-patient at good old St. Barts on and off from a girl and here we are in a small village without Medical advise and dont know how to Manage I hope you will pardon me for asking I am Enclosing a postal order for a shilling and will willingly pay more if it is required from an old patient."

The last is from a patient whose name is on the books for admission. She had an inguinal hernia. "Sir, Would you kindly let me know when I am coming in to go under my operation as I think I have waited long enough it is just 10 weeks since I first came to the hospital, and I came up a fortnight ago and you said it was a mistake and you would look it up and send the next week and I have not heard yet and my husband is get rather out of temper over it he said while I am waiting I am get worse and not better so you might let me know as soon as you can as I should like to get the operation over as soon as I can as I am feeling very bad lately." S. W. B.

THE DUGGOUT MSS.

From "The Athenæum," April 6th, 3333.

IN the course of recent excavations on the frontiers of northern Boschia the distinguished archæologist, Prof. Cyrus G. Whizz, of Toshville, Pa., has discovered a most interesting series of remains dating back to the barbarian invasions of the twentieth century, including MSS. probably cœval with the famous "Mud Hall" or "Errorregretted" Tractate. One document in particular (S/mr 54321) gives most valuable information on the religious tenets of this epoch. The MS., which is English of the Middle Georgian dynasty, is in holograph, written on sheets of poor quality paper, headed in printed letters "A.F.2121." The document, probably a protocol, abounds in glosses and erasions. From other papers found in the same cave—MSS. bearing the formula of invocation, "Foryourinformationandactionplease," and incunabula relating to "Feet bitten frost prevention of"—coupled with the discovery of a very well-preserved mummy in an adjoining cave, Professor Whizz deduces that the author was a Reggi-mentalmedikkalorfisser, a member of a lowly but dreaded class of the priestly or Luddybrahzat caste, who died—as these men frequently did—of mental inanition and hæmorrhagic kyphosis. From internal evidence it is safe to assume that the MS. dates to the first ten or fifteen years of the war, as reference is made to "rifles"—archaic weapons abandoned in favour of primitive bows and arrows at least fifty years before the final extirpation of the Hunderpest.

Translation of the document:—

During the past months and years of subterranean seclusion I have reviewed all the sins of my past life—after all, there is no other amusement. I have meditated on the normal tonsils I enucleated, on the furuncles I submitted to Schwartzes, on the straight septa I resected; but most of all have I pondered on the night when I accidentally became a [two words illegible]. It was two years before the war—to be precise on Tuesday, February 28th, 19—. I was a cutter then, and my firm came off duty at midday. On that day I did thirteen blood counts. When I handed the last three to my HS and expectantly awaited his thanks, he informed me casually

that one patient had discharged himself, one had already died, and the third had been recognised by Herbert and several members of the Senior staff as a gentleman suffering from an inordinate passion for laparotomies. He then wrote "HSD" on his board and left hurriedly. Shaking the dust of the R.S.Q. from my feet with a suitable word or two, I went in search of a beefsteak which I found somewhere near Chancery Lane. By 8.30 I felt much better and returned to my rooms. With great presence of mind I carried a volume of Choyce, which looked offensively aggressive, with a newspaper, and took a Kipling at random. Then things began to go wrong. The fire smoked, a cinder fell into the milk, my pipe would not draw, and I had got hold of "The Plain Tales" and wanted "Kim."

I went to the window. It was a beastly night. The wind was getting up and the rain was coming down. Lamps shone sulkily on wet pavements, and in a house opposite someone played ragtimes. Then down the deserted street there pranced stealthily a conspirator. He was obviously a conspirator and obviously in love with his profession. For no other reasons would anyone prance stealthily on a wet night in so uncomfortable and conspicuous a costume as a black mantle, a mask, sombrero and cock's feather. Exactly how I got into the street I never know, but I do know that a desire for vengeance on the upper middle classes in general, and my HS in particular, lent me speed. The stranger gripped my arm. "Any Tb. found?" he hissed. Automatically I breathed the familiar reply, "None present!" "Good—Good!" He almost ejaculated, "I knew you were one of us! But hurry! Hurry! We are already late, and to-night we brew the vaccine of vaccines!" Strangely thrilled by his words I joined in his headlong course. Faster and faster we went; we crossed the river; we passed through Clapham and through Balham—through places, such as Tooting, that I had never believed in before; and as the country grew wilder and more desolate, so we went the faster till we seemed to outstrip the howling wind. And now the night was full of noises. Strange shapes flapped past us yelling and muttering, but all were crying the same thing, "The vaccine—the vaccine!" Suddenly we stopped in a dreary and ghoulish plain waste. A large notice-board showed the words "To the Blasted Heath," and in the distance the sky was lit by the sinister glow of a red-hot autoclave, round which there danced a ring of white-coated figures shrieking a horrible chorus that seemed to run :—

"Colonies of streptoccocus,
Tubes of Agar grey;
Stain and Culture—Stain and Culture,
Ye that Culture may!"

Then, too late, I realised what I had done. Unwittingly I had intruded on a witch-sabbat of Pathologists! My blood nearly coagulated with terror, but there was no means of escape. I plunged into the thickest part of that unholy concourse, and listened in horror to the frightful blasphemies that resounded on every side. An elderly wizard entered into conversation with me. He introduced himself as Dr. Faustus. I asked him if it was true that he had been torn in pieces by several devils? He protested, on his honour, that the episode had been greatly exaggerated. "That was Marlowe's doing," he said. "Dear old Bill Shakespeare, that most original pathologist . . ." "Pathologist?" I asked. "To be sure; it was he who first worked out the so-called Wassermann reaction. Surely you remember the preparation of the antique, 'Liver of birth strangled Babe . . .'" Suddenly we were interrupted by a most extraordinary uproar. "The Amboceptor!" cried all the sorcerers, "The Amboceptor himself!" and a stately personage advanced through the crowd. I recognised him at once. That was not exactly the name under which he was usually known; but his frontal development, his well-marked caudal vertebræ and the curious malformation of his feet made mistakes impossible. Enthroning himself on the red-hot autoclave and fanning himself gently with his tail, the Amboceptor began a short speech: "My most beloved subjects—A few hundred years ago witches and sorcerers were my special *protégés*, and it is with the deepest and most heartfelt gratitude that I meet you to-night. Truly you carry on the good work. They drew their victims' blood—so do you! They cooked it according to a careful ritual—so do you! They readministered the fluids like you, and their subjects died in horrid agonies—so do—ahem!" (here his Majesty was seized with a violent fit of coughing). He continued: "To-night I am with you for a great event—we brew the vaccine of vaccines! You know how some of my dear servants in that spiritual home of mine upon the Elbe have discovered a new disease—the pan-lecithin syndrome of Dumpkorf and Doustor-swivel! It has only one disadvantage—it doesn't exist. But this can be remedied. Once the vaccine is brewed . . ." He stopped, then suddenly: "There is an intruder among us!" he thundered. "Oh, impossible, your majesty!" said one of the courtiers. "Nonsense! I tell you there is! I distinctly saw a man with a stain of aniline gentian violet on his forefinger! Do you mean to tell me that any demonstrator would so far forget himself as to stain a film or a section? That man has been working—yes, working!" Only one thing could have saved me, and that one thing happened; the autoclave exploded, and I was hurled through the air till I came down on the floor of my sitting-room. . . .

The rest of the MS. is missing. "ESTOC."

STUDENTS' UNION.

COUNCIL Meeting May 4th, 1916, Mr. Waring in the chair.

It was suggested and agreed to that the small surplus remaining over from the subscription to the Etherington Smith Memorial Fund be applied to the purchase of one or more shares in the S.B.H. Catering Co.

Any old Bart.'s men who wish to dispose of shares are invited to communicate with the Secretary.

CORRESPONDENCE.

SKEY'S LAST LECTURE.

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

SIR,—On reading over Mr. Dunn's letter in your current issue, a possible explanation of our differing accounts occurs to me.

Skey was announced to give four lectures. At the first two I was present, and I remember them perfectly. The first began, as aforesaid, "What's the use of Tincture of Iodine?" The second began, "Gentlemen, I once delivered a lecture before the Royal College of Surgeons on a piece of string." Then he held up a piece of ligature silk, and proceeded to lecture on the various surgical uses of a piece of silk—ligatures, sutures, and "old, forgotten, far-off things, and setons long ago." He was keen on the treatment of fistula in and by a loosely-tied ligature, left to cut its way out. So was Holden. On the strength of their teaching, I tried it myself a few times in the early years of practice; but I never got very satisfactory results from it, and gave it up.

There remains a third lecture. That, frankly, I remember nothing whatever about. And it is probable, as Mr. Dunn suggests, that I was not there, and that he was. That accounts for his having witnessed the painful scene which he describes, and which, I am happy to say, I did not witness. And that *was*, as a matter of fact, Skey's last lecture; but it was *not* his last appearance at the hospital. He came to lecture again the following week. I was going to this lecture, and somehow I was a few minutes late, and as I reached the foot of the stairs of the Anatomical Theatre, there were three or four men coming down. One said to me, "No lecture." "Why, what's up?" "The old man came to the door, looked in, said he never had lectured to four men, and he'd be damned if he ever would!—turned on his heel and walked out again. Poor old buffer!"

As to that I am absolutely certain. Circumstance and phrase fixed it firmly in my recollection. I wish I could remember who were the men coming downstairs; but that is a sheer impossibility. Is it not possible that, even now, one of them may see this letter, and remember the circumstance?

I am sorry that the old tale has been dug up, and put into cold print, forty-and-four years after its occurrence. It would have been better left to the forgetfulness that must have soon been its portion.

HARRY LUPTON.

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

DEAR SIR,—An error has crept into your Editorial Notes of May number. Dr. Warrack has recently been appointed as my "deputy."

Yours faithfully,
W. M. WILLOUGHBY,
M.O.H., Port of London.

P.S.—The appointment of M.O.H. was made on February 3rd.

May 22nd, 1916.

ST. BARTHOLOMEW'S HOSPITAL WOMEN'S GUILD.

THE Fourth Annual Meeting was held as usual on View Day, in the Great Hall, in which were spread two tables decorated with flowers. Lady Sandhurst received the guests and afterwards presided at the Meeting. The usual business was transacted, and a resolution, moved by Capt. Elmslie and seconded by Mrs. Tooth, was passed, authorising the Guild to spend £5 a year on helping children referred to the Hospital by the Invalid Children's Aid Association. It is not a large sum, and we wish our funds enabled us to do more social work in connection with the patients; however, this is a beginning, even though a small one.

In the absence of Lord Sandhurst, who was unable to stay for the Meeting, Sir Anthony Bowlby, on leave from the Front, proposed a vote of thanks to Lady Sandhurst. In eloquent terms he spoke of the heroism of our soldiers, and how well indeed they are worth all the Guild can do for them.

Our membership showed last year a great increase owing to the war. This year we have nearly one hundred fewer names in our Report. We much hope our next Report will show an improvement. Are there not many ladies interested in St. Bartholomew's who have not yet joined us, and may we hope they will do so now?

MILLICENT MOORE,
Hon. Sec.

REVIEWS.

CLEFT PALATE AND HARE LIP. By Sir W. ARBUTHNOT LANE, Bart., M.S., F.R.C.S. Third edition. Pp. 102. (London: Adlard & Son.) Price 10*s*.

Sir Arbuthnot Lane's book on cleft palate is not to be recommended to students; it is meant for those engaged in the practice of surgery. The book is a monograph, not only in the sense that it treats of a single subject, but also in the fact that it deals only with the views of the writer. In the main part of the work no changes of importance have been made, although a short statement has been introduced dealing with the immediate mortality of the author's method of operation, the reader will still look in vain for any consideration of the ultimate results. This is surprising, in view of the excellence of recently published series of cases treated by the older operation of Langenbeck, and considering the widely held belief that the results of the "turn-over flap operation" compare unfavourably with these.

The book now contains very interesting new chapters on "Speech Training," by Mr. Cortlandt MacMahon," and on "Dental Treatment," by Mr. Warwick James.

SERUMS, VACCINES, AND TOXINS. By W. C. BOSANQUET and J. W. H. EYRE. (Cassell & Co.) Pp. 456. Third edition. 9*s*. net.

A fairly complete little volume dealing with treatment, diagnosis, and prophylaxis. The usual chapters on immunity and resistance open the book, and are not as full or concise as would seem necessary to us; the later portions of the work, dealing with specific diseases and reactions are, however, excellent. In this new edition considerable space has been devoted to chemotherapy and the action of arsenical compounds and dye-stuffs upon protozoal para-

sites. We agree with the author that, although these are scarcely serums, vaccines, or toxins in the usual meaning of those words, yet their action depends upon fundamentally the same principles and makes their inclusion necessary.

THE AFTER-TREATMENT OF OPERATIONS. By P. LOCKHART-MUMMERY. (Baillière, Tindall & Cox.) Pp. 275. Fourth Edition. Price 5*s.* net.

This little work is well known to many of our readers, and its importance to house-surgeons cannot be over-rated. At the present moment, with so many "physicians" pitch-forked by the war into surgical wards, the appearance of a new edition is very opportune. A new chapter on gunshot wounds has been added, and the chapter on surgical shock has been re-written. The after-treatment of abdominal cases has received special attention and is excellent in every way. The book can be confidently recommended to all newly qualified men and to such others as have charge of surgical wards or operation cases.

THE PATHOLOGY OF TUMOURS. By E. H. KETTLE. (H. K. Lewis & Co.) Pp. 224. Price 10*s.* 6*d.* net.

This excellent little work deals chiefly with neoplasms and their differential diagnosis. The text is short and concise, and the illustrations, many of which are coloured, are very clear and in the main typical, though, as might be expected where most of the illustrations are original, a few appear to be so atypical that one would not recognise them without a close perusal of the text. The photographs of naked-eye specimens are especially good, and the book should be of great service to students taking the higher examinations.

DISEASES OF THE NOSE AND THROAT. By SIR STCLAIR THOMSON. (Cassell & Company, Ltd.) Pp. 858. Coloured plates 22. Second edition. 25*s.* net.

This well-known work was first published four years ago, but since that date advance in rhino-laryngology has been steady, consequently this edition has been revised from beginning to end, and most of the new methods have been included. A description of suspension larygoscopy has been added, as also the technique of nerve blocking to obtain laryngeal anæsthesia. New sections on intra-nasal dacryocystostomy, and on the nasal route to pituitary tumours, have also been added. The text is clear, and the many illustrations are excellent. The volume is quite up to date, and should be of great service to senior students, and the increasing importance attached to the diseases of the nasal passages in everyday work should render the book of much value to practitioners as a work of reference.

EXAMINATIONS.

UNIVERSITY OF CAMBRIDGE.

Second M.B. Examination. May, 1916.

Part II: Pharmacology and General Pathology.—B. F. W. Armitage, C. V. Braimbridge, G. E. Burton, A. J. Copeland, E. G. D. Murray, E. D. Spackman, H. F. Squire.

UNIVERSITY OF LONDON.

Second Examination for Medical Degrees. March, 1916.

Part I: Organic and Applied Chemistry.—C. L. Hewer, J. N. Leitch, W. E. Lloyd, N. S. B. Vinter.

Part II: Anatomy, Physiology and Pharmacology.—W. B. Christopherson, H. C. Cox, R. Coyte, H. N. Hornibrook, M. Jackson, R. J. Perkins, B. B. Sharp, G. P. Staunton, N. Synn, A. D. Wall.*

* Distinguished in Anatomy.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

At the meeting of the Royal College of Physicians of London held April 27th, 1916, the following were admitted:

Fellows.—J. A. Arkwright, E. A. Cockayne.

Member.—H. H. Scott.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Final F.R.C.S.

The following were successful at the Final Examination for the Fellowship held in May, 1916:

R. S. Lawson, C. W. B. Littlejohn.

Primary F.R.C.S.

The following were successful at the Primary Examination for the Fellowship held in May, 1916:

H. B. Bullen, R. J. Perkins.

CONJOINT BOARD EXAMINATION.

April, 1916.

The following have completed the examinations for the Diplomas of M.R.C.S. and L.R.C.P.

P. O. Ellison, K. D. Atteridge, E. A. Fiddian, N. N. Haysom, D. S. Brachman, S. G. Dunn, R. C. Davenport, L. W. Evans, P. S. Clarke, J. Aydon, R. R. Powell, H. M. Cohen, W. F. Eberli.

NEW ADDRESSES.

L. B. CANE, Station Hospital, Dilkusha, Lucknow.

G. CAWLEY, Port Shepstone, Natal, South Africa.

G. V. WORTHINGTON, Mangalore, Llandrindod Wells. (Has relinquished his temporary Commission in the R.A.M.C.).

APPOINTMENTS.

W. E. L. DAVIES, M.R.C.S., L.R.C.P., appointed District Medical Officer of the Newtown and Llanidloes Union.

Lt.-Col. F. E. SWINTON, I.M.S., appointed Deputy Director-General of the Indian Medical Service.

J. S. WARRACK, M.D.(Aberd.), D.P.H.(Cantab.), appointed Deputy Medical Officer of Health for the Port of London.

BIRTHS.

BODY.—On May 11th, the wife of Thomas M. Body, R.A.M.C., of Dowlais House, Middlesbrough, of a daughter.

DOTTRIDGE.—On April 4th, at 12, Portland Court, W., the wife of Cecil A. Dottridge, M.B., of a daughter.

MARRIAGE.

RYLAND—MOORE.—On May 17th, at The Hirsel Private Chapel, Coldstream, N.B., Capt. Archer Ryland, F.R.C.S.Ed., and R.A.M.C., son of Mr. and Mrs. Woodcoat Ryland, of 43, Holland Park, London, W., to Gladys Mary, daughter of the Rev. C. A. Moore, Domestic Chaplain to the Rt. Honble. the Earl of Home, K.T., and Mrs. C. A. Moore, of The Hirsel, Coldstream, N.B.

ACKNOWLEDGMENTS.

Guy's Hospital Gazette, The Nursing Times, New York State Journal of Medicine, Long Island Medical Journal, Middlesex Hospital Journal, The Shield, St. Mary's Hospital Gazette, St. Thomas's Hospital Gazette, British Journal of Nursing, The Hospital, London Hospital Gazette, Giornale della R. Società Italiana d'Igiene, L'Attualita Medica, The Medical Review, Otago University Review.

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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All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City* 510.

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St. Bartholomew's Hospital

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

JOURNAL.

VOL. XXIII.—No. 10.] JULY 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Mon.	July	3.—Second Exam. for Med. degrees (London), Part II, begins. M.D. and M.S. Exams. (London) begin. Second Exam. of Soc. of Apothecaries begins.
Tues.,	,,	4.—Final Exam. Conjoint Board (Medicine) begins. Dr. Garrod on duty.
Wed.,	,,	5.—First Exam. of Soc. of Apothecaries begins.
Thur.,	,,	6.—Final Exam. Conjoint Board (Midwifery) begins.
Fri.,	,,	7.—Final Exam. Conjoint Board (Surgery) begins. Dr. Calvert and Mr. Bailey on duty.
Sat.,	,,	8.—Oxford Trinity Term ends.
Mon.,	,,	10.—First Exam. for Med. degrees (London) begins.
Tues.,	,,	11.—Dr. Morley Fletcher on duty.
Thur.,	,,	13.—Second Exam. for Med. degrees (London), Part I, begins.
Fri.,	,,	14.—Junior Scholarship Exam. Dr. Drysdale and Mr. D'Arcy Power on duty.
Sat.,	,,	15.—**Summer Session ends.**
Tues.,	,,	18.—First Exam. Conjoint Board begins. Dr. Tooth on duty.
Fri.,	,,	21.—Dr. Garrod and Mr. Waring on duty.
Tues.,	,,	25.—Dr. Calvert on duty.
Fri.,	,,	28.—Dr. Morley Fletcher and Mr. McAdam Eccles on duty.
Tues.,	Aug.	1.—Dr. Drysdale on duty.
Fri.,	,,	4.—Dr. Tooth and Mr. Bailey on duty.

EDITORIAL NOTES.

THROUGH the instrumentality of Dr. Horton Smith Hartley, a gift of a billiard table has been made to the Junior Staff. The donor is Sir Lumley Smith, K.C. The table is in excellent condition and is supplied with all the necessary equipment.

The Governors of the Hospital have very kindly divided off a section of the basement of the new Surgery and fitted it up as a billiard room. The manner in which this has been done makes the room one of great comfort and a suitable housing for the very fine table which has been presented.

The thanks of the Junior Staff to both Sir Lumley Smith and the Governors of the Hospital cannot be expressed in any other way than by the good use which they make of it. On May 3rd, 1916, the Junior Staff entertained Sir Lumley Smith to dinner in their quarters, and on this night the table was used for the first time. Mr. Hayes, as representing the Governors of the Hospital, was invited, but unfortunately he was unable to be present. The Warden took the chair, and Mr. Green, in a speech of well-chosen words, thanked the donor. Sir Lumley Smith, in replying, hoped that the Junior Staff would benefit in their recreations by utilising the table.

* * *

The billiard room is for the use of the members of the Junior Staff only. Others are not allowed to play in this room unless they are invited to do so by a member of the Junior Staff, and if they so play, one of those playing must be a member of the Junior Staff. The room is not to be opened until after 5 o'clock in the evening. The control of the room is in the hands of the Warden.

* * *

With very much regret we learn that the son of yet another of our Consulting Staff has died as the result of wounds. Lieut. J. D. Champneys was officially reported "missing, believed wounded," in France on November 22nd, 1915. He is now known to have been captured by the Germans and to have died of his wounds the following day. He was educated at Rossall School and Balliol College, Oxford, taking honours in the Final School of Laws. Our deepest sympathy is extended to Sir Francis and Lady Champneys in their bereavement.

* * *

It is with the greatest regret that we have to record the death of Lieut. H. J. S. Kimbell, R.A.M.C., who died of pyæmia on May 28th after a lingering illness. At the time he contracted his illness he was holding an appointment at the Preston Hall Hospital, near Maidstone. Our deepest sympathy is extended to his relatives and friends.

* * *

It is with much pleasure that we are able to announce

that Colonel H. Hendley, M.D., I.M.S., has been appointed to hold charge of the office of the Director-General, I.M.S., in addition to his own duties of Inspector-General of Civil Hospitals of the Punjab; also that Lieut.-Colonel F. E. Swinton, I.M.S., has been appointed to be Deputy Director-General, I.M.S.

FROM THE FRONT.

SOME EXPERIENCES AND TIPS FROM A BASE HOSPITAL.

THE following notes may be of some interest to any recently qualified men who happen to find themselves at a Base Hospital. Senior men will certainly make the remark that there is nothing new in all this, and scientific men will quite rightly say that statements are made that cannot be backed up by any scientific data.

The surgical work at a base hospital consists chiefly in fighting against sepsis.

For the first four months of the war my work consisted in treating the lightly wounded. I was then put in charge of the surgical cases, and was persuaded to use hypertonic saline for the acute stages of sepsis. It may be worth mentioning here that a number of people consider this treatment to be useless, but this, I think, is because they continue using hypertonic saline after the acute stage is over. There is no doubt that it is possible to overdo the salting treatment. This is also true of continuous baths.

At the time when the hypertonic treatment was suggested I had several cases which had been treated by antiseptics, and the change that took place after using salt was little short of miraculous. About August, 1915, it was suggested that I should open up the septic wounds and pack them with tablets of salt wrapped in gauze and then leave them for several days without dressing them. I found that in spite of the accumulation of pus the temperature did not rise, and that on cleaning this pus away one found the most beautiful granulating surface that one could wish to see. There are, however, one or two things that I should like to emphasise.

The question of "non-dressing" is an important point. The exposed surface in some of these patients with multiple wounds amounts to a square foot or more. Imagine then what it must mean to have that dressed three times a day. The anticipation of the pain is always present. In some cases it is true that anæsthetics are given, but the effect of the anæsthetic is extremely harmful in such toxic cases. As the result of nine months' experience in this treatment one can definitely state that if the pulse and temperature do not fall considerably in the first three days the wound should be dressed in order to see *whether further drainage* is necessary, but in the majority of cases the dressing *per se* will do no good at all. As a rule, after the first dressing we do not use "soloids," but pack with gauze soaked in eusol 5 per cent. and saline 10 per cent. Personally I prefer during the acute stage to keep the dressings moist by watering them with saline. The triangular bandages will be found very useful, as they can be tied on the top of the limb and untied whilst the patient is asleep without disturbing him. At the same time they do not prevent the air from getting at the wound. Before leaving this part of the subject I would urge a prolonged trial of the "non-dressing principle," and that whilst temperature and pulse are falling pus and smell *per se* will do no harm.

Talking of temperature and pulse, I should like to impress the very obvious fact that a temperature chart without the pulse rate is waste of time and paper.

In dealing with large numbers of wounded such as occur after a big engagement, it is the feel of the pulse and the pulse rate which indicate whether a man can travel further without danger. Again, when one has to decide whether it is necessary to amputate a septic limb, it is the pulse rate during the last week that decides the question. The question of amputation is one perhaps which causes me more anxiety than any other, and there is much truth in the remark made by Major Hull in his book: "The loss of a limb is a surgical failure, but the loss of life is a calamity; and the loss of life after amputation is a frank admission that the surgeon did not know when to operate." Experience alone can teach one when to amputate, and it is useless to try and write down hints. The importance of flapless operation has been emphasised by Colonel Gordon Watson and others, but I do not think that enough emphasis has been laid on the benefit of lumbar anæsthesia in amputation of the lower extremities. This question is so important that I should like to pass on a few hints that bitter experience has taught me.

(1) Do not think it is difficult to give a spinal anæsthesia.

(2) Do the first two or three under general anæsthesia on patients who are not very ill.

(3) Give the patient omnopon, a third of a grain, half an hour before.

(4) See that the buttocks and shoulders are raised enough to give the curve with convexity downwards, the lowest point corresponding to about the first lumbar vertebra.

(5) Put the patient on the side of the affected lower limb.

(6) Boil cannula in water *without* soda. Distilled water is best. Soda destroys the stovain.

(7) Do not put cannula or syringe in any antiseptic such as alcohol, etc. Most people consider stovain and glucose, as prepared by Poulene Frère, to be the best. Anæsthesia, in the majority of cases, is complete after three to eight minutes. As soon as the anæsthesia has reached the level of the buttocks the patient should be turned on to his back. Not infrequently the patient feels a little sick about

ten minutes after the injection, but if he takes a deep breath and holds it this feeling of nausea soon passes off. I am convinced that lumbar anæsthesia is the very best way of diminishing surgical shock. To see a patient who ten minutes previously has had an amputation through the thigh, sitting up eating a hearty meal, is the best advertisement for this method, and why it is not more used I cannot understand.

(8) Insert the cannula *in the middle line* between the spines of lumbar vertebræ three and four—not to one side, as so many books suggest.

(9) Make the patient "round" his back as much as possible.

The treatment of compound fractures is one of great importance. Everybody now is familiar with the splints devised by Colonel Robert Jones, and so there is no need to describe them here. The "bed lifts" made by Messrs. Carters do not seem to be used as much as they deserve. They are invaluable, and can be easily put together without disturbing a patient at all. There is one important point, however, namely, to see that the canvas slings are loosened every time after use, otherwise the patient will get bed-sores. The advice about "non-dressing" applies equally to compound fractures as to simple flesh wounds. The question of removal of bone in some cases is a difficult one, but, in my experience, it is best to leave as much bone as possible the first time the wound is drained. If, however, the case runs an unfavourable course and further drainage is necessary, then it is advisable to remove all the small pieces.

The other two lines of general treatment I mentioned are continuous irrigations and continuous baths. Since adopting the method of "saline packing" we have not used baths and irrigations to the same extent. The cases for which a bath seems to be of greatest benefit are those where the circulation is poor and the whole limb is swollen. Frequently patients have arrived in hospital with a leg or arm tense and swollen, and the question of immediate amputation has arisen. In such cases multiple incisions and continuous baths for forty-eight hours or more have often saved the limb. The leg bath described in the *Lancet*, May 8th, 1915, is a very useful one, but it must be remembered that, after the acute stage is over, baths are of little use.

Fomentations, like the Dodo, are extinct, but, unlike that noble bird, they have their use occasionally to relieve pain, and give great benefit for superficial infections such as cellulitis.

One final tip let me give. Keep a note of all your failures, and write down at the time what you think might have been done in such cases.

MALCOLM DONALDSON.

THE INTERNMENT OF SICK PRISONERS OF WAR IN SWITZERLAND.

By A. L. VISCHER, M.D.Basle, M.R.C.S.Eng.

IT may interest the readers of the ST. BARTHOLOMEW'S HOSPITAL JOURNAL to hear some details about the scheme for the tending of sick prisoners of war which is now being carried out in Switzerland.

The first suggestion to intern sick prisoners of war in a neutral country came from Monsieur Gustave Ador, President of the International Committee of the Red Cross at Geneva. Thanks to the efforts of the Pope, who acted as intermediary at the beginning of 1916, an agreement was signed between France and Germany to the effect that a certain number of sick and wounded prisoners were to be removed from the prisoners' camps and interned in Switzerland for the rest of the duration of the war. As there are more French prisoners in Germany than Germans in France it has been stipulated that for three Frenchmen one German was to be sent to Switzerland. Two Commissions, each consisting of twenty officers of the Swiss Army Medical Corps, were appointed, and entrusted with an inspection of the various prisoners' camps in France and Germany in order to select the men to be interned. The agreement mentioned as proper cases for internment chiefly tuberculosis, chronic diseases of the respiratory tract, heart disease, arteriosclerosis, nervous diseases, and invalidity through gunshot wounds.

The practical realisation of the whole scheme is the work of Colonel Hauser, the Chief of the Swiss Army Medical Corps. For that purpose Switzerland has been divided into a certain number of districts, at the head of each of which is placed a Swiss army doctor. Each place where there are interned prisoners has a commanding officer, to whom a hotel manager is attached as special adviser. The home countries of the prisoners are paying four francs per diem for each soldier and six francs for each officer. This shows that there can be no question for the hotel-keepers of making fortunes by the arrangement. The appetite of the men is astonishing. In one place the average gain of weight of the soldiers during one week was 2 kilograms. A few details about the food may be interesting. Breakfast consists in milk, coffee, butter, and jam. The daily ratio of bread is 400 grm., of milk 750 grm. Dinner consists in soup 500 grm., meat 175 grm., 500 grm. potatoes, and 100 grm. vegetables. For supper the men receive soup, cheese or lard, rice, macaroni, etc.

The places which have been selected for internment are all well-known health resorts like Thonne, Grindelwald, Zermatt, Weggis, etc. The men are quartered in good second-class hotels. Those suffering from phthisis are sent to Leysin, Montana, Arosa, and Davos.

As there are many soldiers who need special surgical or orthopædic treatment, a special hospital has been organised by the Swiss authorities at Lucerne. At the head of this institution a distinguished surgeon, Mr. H. Brun, lecturer on Surgery at the Zurich University, has been appointed.

Only a few weeks ago an analogous agreement has been signed between Great Britain and Germany. At this moment Swiss officers are proceeding to England and Germany to select in the prisoners' camps of those countries a certain number of patients for internment. The Swiss authorities have already received numberless offers from places which would like to receive English soldiers. It is expected that most of the Englishmen will be quartered in Château-d'Oex, the famous winter resort in the Canton de Vaud.

These are only the outlines of this great work of internment and care for the sick. Switzerland will do her utmost to make it a full success and a real blessing for all those brave men who in the fight for their country have lost their health and their freedom.

BREATHING AND PHYSICAL EXERCISES FOR USE IN CASES OF WOUNDS IN THE PLEURA, LUNG, AND DIAPHRAGM.*

By CORTLANDT MACMAHON, B.A.Oxon.
Instructor for Speech Defects at St. Bartholomew's Hospital.

THE exercises herein described have been used since the early months of the war on a large number of soldiers suffering from wounds of the pleura, lung, and diaphragm, in St. Bartholomew's Hospital, Guy's Hospital, King Edward VII's Hospital for Officers, Princess Henry of Battenberg's Hospital for Officers, No. 1 Base Hospital, the Hospitals for Officers at 17, Park Lane, and Dorchester House, Mrs. Hall Walker's and Mrs. Herbert Samuelson's Hospitals for Officers. The exercises are now set out in the hope they may be of general use in similar cases.†

The chief objects of the exercises are :

(*a*) To prevent pleural adhesions forming and to break down existing adhesions by careful and gradual movements.

(*b*) To enable lungs, which have collapsed owing to pressure due to empyema, hæmothorax, and pneumothorax, to regain their normal condition.

(*c*) To reduce hæmothorax and pneumothorax.

(*d*) To restore the normal shape of the chest walls which have fallen in owing to collapse of the lungs.

(*e*) To assist the discharge of pus, where there is a drained empyema, by increasing the lung inflation.

(*f*) To improve the general condition by the tonic effects of the exercises, and especially to overcome breathlessness on exertion.

The early exercises can be carried out without moving the patient from his bed. At first an operator is necessary, who should, if possible, give the exercises daily for about a fortnight, after which time the patient can perform most of them for himself, and they should then be carried out night and morning half an hour before a meal. Great care must be taken that there is no exhaustion to the patient ; only a few exercises should be given at each treatment, and after every six movements of each exercise a rest of at least two minutes should be given. It is advisable that only the first three movements of the exercises should be given for the first three days of the treatment, and, in a case of empyema that has recently undergone operation, the first four movements only should, as a rule, be given until the drainage-tube is removed, but when the temperature has remained normal for some days more extensive movements may be applied.

When the patient can be moved from bed the exercises should be carried out on a narrow couch or table. The free movement of the arms in all directions is essential. Special attention is called to the fact that all the exercises are carried out in a recumbent position, and that on the correct performance of the first three exercises depends the success of the others. Care must be taken that the upper chest is not drawn up nor the abdominal wall contracted during inspiration. These are the two great faults often found. Any protrusion of the abdominal wall during inspiration must also be guarded against. The time of commencement of the exercises, their extent and duration, are matters entirely for the physician or surgeon who has charge of the case. A marked improvement in the appetite, the sleeping, and the general appearance will, as a rule, be noticed within a week of the commencement of the treatment.

The exercises are as follows, it being clearly understood that only a few should be carried out at each treatment, and the advance through the exercises should be gradual, and special exercises selected to suit the individual condition. Each particular exercise should be carried out eighteen times, with a rest, as already stated, after each six movements of the exercise.

(1) The operator places his hands on the side of the lower ribs level with the breast-bone. The patient should breathe in through the nose, and the lower ribs should be felt to be expanding strongly. There should be as little movement as possible of the upper chest. When the fullest inferior lateral costal expansion is acquired, the patient should breathe out through the open mouth and the ribs should be felt to regain their normal position.

* See also the *Lancet*, October 2nd, October 9th, December 4th, 1915, and January 29th, 1916, and the *Brit. Med. Journ.*, January 22nd, 1916.

† For a description of cases treated see paper by C. MacMahon in vol. xxxix of the *Proceedings of the Medical Society of London.*

(2) The abdominal wall should be contracted inwards and then allowed to recover its normal position, so that an in-and-out movement is made. (This is a physical and not a breathing exercise and can be carried out twenty to fifty times.)

(3) Combine the above movements, *i. e.* the patient breathes in through the nose and the lower ribs are felt to be strongly expanding. The mouth is opened wide and the abdominal muscles slowly and strongly contracted, so that the air is driven from the lungs.

(4) The same inspiratory movement, but the breath should be held and the abdominal muscles contracted in three to five deliberate movements before breathing out.

(5) Bend the body laterally away from the side of the injured lung to the fullest extent, so that the uninjured side of the thorax is partially compressed. The patient is on his back, and the head and feet are drawn round as far as possible. The operator should press over the uninjured lung with both hands and the patient should breathe, as before, in through the nose and out through the mouth, contracting the abdominal muscles as he breathes out. (When there has been considerable collapse of the ribs on the side of the injured lung, and especially when there has been an abscess in the lung, great care must be taken in doing this movement, otherwise considerable muscular discomfort will occur within a few hours. A certain amount of pain will necessarily be felt if there has been a serious collapse in the chest wall, but this can, of course, be relieved.)

(6) The same movement and position, but the operator should press with his hands on the side of the uninjured lung with a pressure of thirty to sixty pounds, and the patient should contract the abdominal wall, with the breath held, at first once, afterwards increasing by degrees to five times.

The following exercises are done with the breath held in :—

(7) Grasp the wrists of the patient as the arms lie at the side of the body, the operator standing behind the patient. Draw the arms outwards and upwards to above the head, pull on the arms steadily when the arms are at their fullest extent, then relax the pull. The patient should then breathe out quickly.

(8) Arms as before. Bring them together in front and carry upwards to a right angle. Part the arms strongly backwards and horizontally.

(9) The same exercise as the preceding one, but the arms are carried backwards at an angle of 45° upwards.

(10) Commence with the patient's arms above the head, with the palms of the hands facing each other. The operator grasps the arms between the wrists and the elbows and presses the arms strongly downwards, and when the elbows approach the sides the abdominal muscles should contract. Force the elbows into the side and make the patient breathe out strongly.

(11) Grasp the right wrist of the patient with the left hand, carry the arm forwards, and bring it to a right angle with the body. The operator should then place his right hand well under the scapula of the patient and pull the arm backwards and downwards as the patient strongly contracts the abdominal wall. Changing the hands, do the same movement on the other arm of the patient.

(12) When there is marked collapse of one side of the upper chest the body should be bent as in Exercise 5, and the wrist of the arm on the wounded side grasped, the arm being fully extended above the head; the patient should then pull the arm downwards with the elbow into the side, and should strongly contract the abdominal muscles as the arm descends. The operator gently pulls against the patient. (This exercise is exhausting unless carried out very carefully; six movements are sufficient during the first few applications of it.)

The earliest time at which the exercises have been commenced has been fifteen days after the insertion of the drainage-tube in cases of empyema, and thirty-three days in cases of hæmothorax from the date of the wound.

Very great care must be taken that the instructions given above are carefully followed, otherwise harmful results might ensue.

When a patient suffering from the effects of a lung wound is convalescent, he should be encouraged to sleep on the side of the injured lung, and when resting by day to adopt the body position described in Exercise 5. This will help recovery by enabling the injured lung to inflate more easily.

A CASE OF ENTERIC FEVER IN WHICH THE B. TYPHOSUS WAS RECOVERED FROM THE BLOOD ON THE 150TH DAY OF THE DISEASE.

BY G. K. BOWES, M.R.C.S., L.R.C.P.

I AM indebted to Dr. Drysdale for his kindness in allowing me to publish the following case. Although cases of similarly or even more prolonged duration of enteric fever have been reported, they are very uncommon.

A. S—, æt. 15½ years, a glass-blower, was admitted to Enfield Isolation Hospital on September 23rd, 1915. According to information kindly furnished by Dr. Cook, the Medical Superintendent, the patient's illness began about September 20th. He was the last of seven cases coming from one house. Four Widal's tests had been made with positive results on some of the others, but this was not done in his case. Another child from the same house was admitted to Great Ormond Street Hospital with

enteric, and three next-door neighbours were admitted to Enfield Hospital with the same disease. The patient had an enlarged spleen, great meteorism, pea-soup stools, but no rose spots. Except for a slight rise of temperature on November 9th he was afebrile as from October 28th.

According to the patient's own statement, he suffered from giddiness and headaches, but no diarrhœa for five days before admission to Enfield Hospital. He was in hospital about eight weeks, and went to bed again for a week on returning home. On getting up he felt very weak, and towards the middle of December his left foot began to swell, the swelling lasting three weeks. Beyond this and a general feeling of malaise he noticed no definite symptoms. On January 6th, 1916, he was sent to a convalescent home at Bexhill, where he remained till January 12th. On the evening of admission at Bexhill his temperature was 99° F., and on the following days it was intermittent, ranging between 96° and 102·2° F. The pulse-rate was from 100 to 132, and did not vary with the temperature. The bowels were open regularly once or twice a day.

From Bexhill he was admitted to St. Bartholomew's on January 12th. On admission the abdomen was somewhat distended and tender, and the spleen was just palpable. No rash was visible. For the week following admission the patient was afebrile. The pulse-rate was frequent, usually rather over 90. The patient was very constipated.

On January 19th the temperature suddenly rose to 101·8° F. and remained up with remissions till February 1st, reaching 103·2° F. on January 22nd. The pulse-rate was frequent, usually between 120 and 130. The patient during this time complained of pain in the right upper quadrant of the abdomen, and of headache; the gall-bladder was not palpable. The abdomen generally was distended but not tender. The spleen was palpable 1 in. below the costal margin, and was somewhat hard. Constipation and diarrhœa alternated. On January 26th the stools were examined and about 30 per cent. of the colonies on Rebipel agar were non-lactose fermenting, but did not give the bio-chemical reactions of *B. typhosus* nor of *B. paratyphosus*, nor of any recognised pathogenic organism. Dreyer's agglutination test was performed on January 26th with the patient's serum, and gave negative results in dilutions of 1 in 25 to 1 in 250 against *B. typhosus* and *B. paratyphosus* A. and B. On January 22nd the leucocyte count was 14,800 and on February 1st 11,600. The heart at the end of this period showed evidence of dilatation and weakness. The lungs were natural.

From February 2nd till February 12th the patient was afebrile, except for occasional slight rises of temperature. His general condition improved. The spleen became softer and smaller. The bowels were not constipated, nor was there diarrhœa. On February 7th the leucocytes numbered 6700; Dreyer's test was positive in a dilution of 1 in 50 for typhoid.

On February 10th the temperature began to rise, and by the 12th reached 102·8° F.; it remained high, generally between 102° and 100° F. The abdomen was tense, and the spleen again became larger. On February 15th a blood culture was made and typhoid bacilli were obtained. The stools were examined, but no non-lactose fermenting organism was obtained. A vaccine was prepared from the organism recovered from the blood, and on February 19th the patient was given two millions of the dead bacilli. The vaccine was repeated in gradually increasing doses at intervals of forty-eight hours, the last dose given on March 13th consisting of 250 millions. No febrile reaction was produced by the vaccines. On March 8th the leucocytes numbered 7200 per c.mm. The temperature began to decline definitely on February 22nd and reached normal on March 5th, where it remained, except for slight rises on the 13th, 16th, and 18th. After March 7th the spleen was no longer palpable. During this period the bowels were open naturally once or twice a day. The mental condition of the patient remained good throughout the illness.

The heart still showed evidence of weakness. The apex beat extended $4\frac{1}{2}$ in. from the middle line in the fifth space. The first sound was heard weakly at the base. The pulse-rate was rather frequent, usually about 100. For this reason the patient was kept in bed for a further period till March 30th, when he was first allowed to get up. On March 27th Dreyer's agglutination test was performed against *B. typhosus* and gave a positive result in a dilution of 1 in 500. The patient was discharged on April 20th, 216 days after the onset, apparently well, except for a rather frequent pulse.

In this history I wish to draw attention to the following points. The duration of the attack is remarkable. The patient first became finally afebrile on the 170th day after the onset of the disease. During this time the patient had at least two relapses, namely, those when he was under observation at St. Bartholomew's Hospital. It is possible that the patient may have had one or more relapses at home. The history to some extent suggests this. Otherwise we must assume a very prolonged interval between the original attack and the first relapse. He became afebrile after the original attack on October 28th, and had fever at Bexhill on January 6th; that is an interval of seventy days, assuming this fever to have been due to a relapse.

The character of the fever at Bexhill, however, is unlike that of the two relapses which the patient had while in St. Bartholomew's Hospital, the large daily range in the former case being especially noticeable. We must consider the possibility that this attack of fever was not due to a relapse, but was an attack of cholecystitis due to *B. typhosus*. The situation of the pain during the first observed relapse suggests this. If this was the case we may then consider the possibility that the *B. typhosus* remained quiescent in the gall-bladder after the symptoms of the disease had subsided, that after a time they multiplied locally, giving rise to a

cholecystitis, and were thus enabled to reinfect the alimentary tract and the system generally.

It is to be noted that the agglutination reaction was negative on January 26th, and was first found to be positive on February 7th, and this absence of the agglutination reaction till the last stages of the prolonged attack may be connected with the tendency to relapse.

Finally the recovery of *B. typhosus* from the blood as late as the 150th day of the disease, although on the fourth day of a relapse, shows the value of blood cultures for diagnosis late in the disease.

THE SO-CALLED "SIMPSON LIGHT": WHAT IT IS AND WHAT IT DOES.

By E. P. CUMBERBATCH, M.B., M.R.C.P.

MUCH has been heard during the past year of the "Simpson light." Announcements of a remarkable discovery have been made in the papers, and fantastic accounts of surprising cures of intractable diseases have been disseminated among the public. Letters of inquiry have reached the writer from different parts of the country, from America, from the "land of ranches and rattlesnakes" (as the inquirer called it), and it seems that reports of the "Simpson light" may spread as far and as wide as the influenza epidemic of 1889-90. In the following pages an account will be given of the origin of the "Simpson light," its nature, how it is produced, and its therapeutic properties.

Origin of the "Simpson light."—In March, 1913, Simpson, a Scottish engineer, was making a research on the affinity of the rare metals for each other. Ores of the metals were raised to the temperature of the electric arc, and it was noticed that the light emitted had "curative effects on the workmen's hands." Cases of "acne" and "eczema" were said to have been cured. Efforts were then made to construct a lamp so that the healing properties of the light could be further investigated. The greatest difficulty was experienced in the preparation, from the ores, of electrodes suitable for use in an arc lamp. Eighteen months and £5000 were said to have been expended before even a partial success was attained. The electrodes had to conduct the electric current, burn as steadily as possible, and not break when heated to the high temperature of the arc. With those that are at present in use the arc is not perfectly steady. It splutters and flares and minute incandescent particles are frequently thrown off from the heated ends of the electrodes. Impurities in the ores melt and form a slag which occasionally bridges the gap between the electrodes, so that the light goes out and further adjustments have to be made. When the lamp is burning a white smoke is formed as a result of the combustion of the electrodes. It rises into the air, and, after a time, the atmosphere of the room is rendered misty. The smoke is ultimately deposited on objects in the room in the form of a white sublimate. It is probably an oxide of tungsten.

The makers of the lamp do not consider it advisable to state the composition of the electrodes, as efforts are continually being made to improve them. They state, however, that the chief constituent is *wolfram*. Wolfram is a tungstate of iron and manganese.

Nature of the "Simpson light."—The light is intensely brilliant. Besides *visible* rays, the arc emits *heat* rays and *ultra-violet* rays. There is no evidence of the existence of any other form of radiation. The therapeutic properties of the light are due, mainly, if not wholly, to the ultra-violet rays. The most familiar and generally used source of ultra-violet light is the Finsen lamp. This also is an electric arc light, but the electrodes are composed of gas carbon. We have to consider, then, in what ways the ultra-violet light from the "Simpson lamp" differs from that emitted by the Finsen lamp. The question has been investigated by Prof. Burstal, Prof. Horton, and Dr. Russ. According to Prof. Horton's measurements the light from the Simpson lamp is from five to ten times richer in ultra-violet rays than that from the Finsen lamp. This means that the duration of the exposure to the light can be much shortened—an important matter in busy hospital practice. Further comparisons can be made by studying the spectra of the light from the two lamps. This can be done by allowing a beam of the light to pass through a prism of quartz and fall on a white screen. The visible rays are thus separated and a coloured spectrum is obtained. The ultra-violet rays are also separated, but as they are invisible to the eye and are not shown on the screen, the latter must be coated with some fluorescent substance which glows when ultra-violet light falls upon it. If this is done, it is seen that the light from the Simpson lamp produces fluorescence over an area that is nearly twice as long as that seen when the carbon arc lamp is used. The ultra-violet spectra can be more accurately compared by allowing the light to fall upon photographic paper. When the latter is developed, the spectra are seen to consist of a number of lines of varying degrees of darkness. Each of these corresponds to a bundle of ultra-violet light rays of definite wave-length. If the exposure is made for a few seconds, it is seen that the spectrum from the carbon arc lamp consists of comparatively few lines except in the region just beyond the visible spectrum; there they are darker and set closer together. In the case of the Simpson lamp the spectrum is longer, the lines are darker and set so closely together that the appearance is almost that of a continuous black band. Longer exposures cause the spectrum of the carbon arc lamp to appear continuous, but only in the region just beyond the visible. It may be concluded from the preceding observations that exposure to the light from the

Simpson arc lamp means irradiation with ultra-violet rays of several different wave-lengths and of relatively even intensity. Exposure to the light from the carbon arc lamp for the same time means irradiation with ultra-violet rays fewer in number, of less variety of wave-length, those of shorter wave-length being relatively much fewer.

We do not know the *modus operandi* of ultra-violet light in producing physiological and therapeutic effects. It is possible that these effects are produced only by rays of definite wave-lengths. The Simpson arc light provides ultra-violet rays of several varieties of wave-length; we may therefore say that if we try to cure disease by ultra-violet light we are less likely to fail when using the Simpson lamp than when using the carbon arc lamp.

It was mentioned earlier that the composition of the electrodes used in the Simpson lamp was not stated by the makers. Wolfram is an important constituent. This contains tungsten. The spectrum of an arc light with tungsten electrodes is apparently identical with that produced by the Simpson arc lamp.

How the "light" is produced.—The Simpsom lamp consists of a metal stand, on which are mounted a pair of electrode-holders. In these the electrodes are fixed, and, by means of a hand-screw, the points of the latter can be moved to and from each other. Behind the electrodes is mounted a plane or concave mirror, and in front of them is a metal tray to catch the flying incandescent particles. The points of the electrodes are brought into contact, and a current of 5–7 ampères at 50 to 70 volts is passed along them. The points are then slightly separated, and a brilliant arc appears. If a large area of the body requires treatment the plane mirror is used so that the light can be diffused over a large area. For smaller areas, the light can be concentrated by the concave mirror.

The smoke given off from the arc has some therapeutic value. By placing a hood over the arc the smoke can be inhaled as it emerges from the summit of the hood. If a paper hood is held over the arc the smoke is deposited as a white sublimate, and the latter can be then collected and afterwards placed in water, so as to form a fine suspension. The smoke is probably an oxide of tungsten.

The properties of the "Simpson light."—The properties of the "Simpson light" are the properties of ultra-violet light. The rays penetrate only for a very short distance into the skin. Those with the shorter wave-length are almost entirely absorbed by ½ mm. of skin. Those with the longer wave-length penetrate a little further, but very few pass beyond 1 mm.

They produce no sensory impression on the skin. After a few hours an erythema arises if the exposure has been for more than a short duration. If the light is 12 inches from the skin it will develop an erythema if the exposure has been for about two minutes, though the time varies with different skins. Longer exposures produce a more intense and long-lasting erythema, and the skin may "peel." No permanent injuries have been produced.

Therapeutic properties of the "Simpson light."—The therapeutic properties are those of ultra-violet light. If cure follows treatment by the "Simpson light" it is necessary, before giving the credit wholly and solely to the Simpson lamp, to be sure that the same result would not have followed exposure to ultra-violet light from other lamps, or other forms of treatment. Some cases of advanced rodent ulcer and lupus that had resisted other forms of treatment have been treated by the "Simpson light" and considerably benefited. With regard to the results obtained in other cases that are worth recording, it must be said that other forms of arc lamp were not tried. With the Simpson lamp, however, the exposures are very short—an obvious advantage. With the mercury vapour lamp the exposures are short, but this lamp does not give rays with such a great variety of wave-length, and the same remark is true of arc lamps with silver, copper, iron, and carbon electrodes. We do not know the *modus operandi* of ultra-violet rays in healing disease. The healing properties may be possessed only by rays of a certain range of wave-length, and if ultra-violet light has the power of curing any disease we are most likely to get the cure if we use the lamp which produces rays of the greatest variety of wave-length.

The white smoke that is produced during the burning of the Simpson lamp can be inhaled, and it may benefit some disorders of the respiratory system. Two cases of asthma have been improved (not cured). A case of tuberculous laryngitis, now under treatment, has benefited considerably. His voice has regained power, and the swelling of the epiglottis has diminished to one half its original size. Time will show whether further and permanent improvement will take place.

THE ROMANCE OF TEXT-BOOKS.

By PERCY DUNN, F.R.C.S.

THERE is a romance about books—text-books which form the close companions of students. Woven in the student's mind is the friendship with which he comes to regard them. Through their pages he sees his way to gaining his ambition, namely, examinational success. Figuratively, he stands facing the banks of a broad river: his aim is to reach the other side. But there is no bridge. He has to make one, and he does so mainly by means of his books. From them he extracts the necessary knowledge, and the bridge being thus firmly and solidly built he passes over the river successfully, attaining the goal of his ambition from an examinational standpoint. And so in after years a student is apt to regard with some

affection the books which formed the constant companions of his student days. Old memories are recalled whenever he happens to glance again at the well-thumbed pages. There are the pencil marks, and the underlined paragraphs calling attention to special details which he desired to memorise; some pages may remind him of midnight hours of study, prolonged by adventitious aid destined to banish sleep; other pages may bring to his recollection occasions when friends joined him for mutual study; and there are the *memoria technica*, pencilled on odds and ends of spaces, now almost or quite forgotten, to remind him of his laborious task. And yet the admission must be made that apart from their old associations, thus depicted, text-books do not belong, generally, to the happy things of life. Sad and inexorable neglect becomes their lot in most cases. Such is their fate, a fate decreed by fashion and time—from which but few escape. From an enviable popularity they may pass to disdainful recognition, and from this to absolute oblivion. The demand for them ceases, nothing can arrest their progress into the unknown, and from that moment their "strange eventful history" comes to an end.

It is not an easy matter to define or explain the causes which precisely determine the popularity of a text-book. To this happy fortune, perhaps, many features contribute. There is first the personal element—that belonging to the author. If the author be popular, and his methods of teaching commendable to students, his book will probably become a reflex of his popularity. His personality is diffused through his pages; throughout an approvable note is sounded, appealing to those to whom his teaching has proved a valuable and a sound acquisition. Thus, edition after edition of his work during his lifetime may be called for, always supposing that the advances of knowledge are incorporated therein.

The test of the enduring popularity of a text-book comes with the death of the author. Then, however, it often happens that his book dies as well. Living authors are always in more request than those whose work has ended with their life, despite even the enterprise of publishers placing the books in the hands of an active and a well-accredited editor. Such a policy, however, is undeniably successful in some cases; thus is explained the survival of certain text-books at the present day, whose title pages evince their early parentage, and which continue, nevertheless, to maintain their supremacy. But, in accord with the advance of knowledge, careful scrutiny will show that with every succeeding new edition, in such cases, there is less and less evidence of the work of the original author. The book is re-vitalised by the spirit of the editor; he raises a new structure upon the old foundations, introducing all the latest modern requirements, and upon the success with which he accomplishes his task depends the continued popularity of a work with which has become identified the teaching of so many generations of students. Literary style, again, in a text-book is an important factor; the style must be easy, attractive, and good, with the information conveyed so well predigested as to allow of rapid absorption by the student. There is, too, the matter of illustrations. Modern enterprise, perhaps demand, has led to a profuseness of figures in the text. Some doubt may be expressed as to the wisdom of this policy, at least to the extent to which it is now being pursued. Profuse illustrations add greatly to the size and cost of a book. In some cases, of course, art reproductions are indispensable, for example, in books upon anatomy. But whether in many other instances the added cost is compensated for by the explanatory value of the illustrations is, I believe, a matter open to question. Still, nowadays, such is the fashion, and inasmuch as author competes against author in this regard, the modern text-book will presumably continue to be thus endowed.

It may now be of some interest to allude to a few instances of the text-books in vogue in the seventies, so far, at least, as Bart.'s students were concerned.

In the dissecting room two books only were generally noticeable, namely, *Holden's Manual of Anatomy*, and the ever green "Gray." Holden's book was popular and had reached its fourth edition at the time under review. The attractiveness of its style and the word pictures of its descriptive details were a predominant feature of its success. One day Walsham asked me a question in the dissecting room in the course of a demonstration. After giving him the answer he said, "I like that." And so did I, and that was the reason I had learnt the answer by heart from "Holden," and was able to repeat it from memory in Holden's words. This incident, of course, was merely a coincidence, nevertheless it shows how the author of a text-book has the power to attract a student's mind by some mode of expression which makes a strong appeal to the memory.

Then as a text-book there was *Holden's Osteology*, of which I feel compelled to add a few words of praise, prompted by a conviction of its value. His descriptions were everywhere interwoven with little sun-light gleams of medical and surgical detail, raising apparent osteological trifles to a position of clinical importance. By this means the bones were endowed with a vitality and an interest wholly unsuspected. The style was eminently attractive; it was as if the dead and dry bones themselves were speaking with the interest which belongs to a personal narrative, and with the intention to excite enthusiasm in the story they had to unfold. And yet this book has passed into the region of the forgotten. Noah, we may presume, possessed an occipital bone. But there is no reason to believe that this differed from the one from which Holden wrote his description. That description, therefore, may be held to remain always true of every occipital bone, differing, however, at the present time, only in the detail of nomenclature which has followed the

B.N.A. innovation. The plates, moreover, of Holden's osteology were distinguishable from having been drawn on stone, and profound testimony is furnished, by their excellence, to the artistic skill of the late Mr. Thomas Godart, of Bart.'s.

The ever green "Gray" may be recognised as the wonderful example of a text-book surviving the onslaught of modern competition. Even in its early days it was a bulky tome, somewhat to its disadvantage. Issued first as long ago as 1853, it has passed through the hands of several editors since the death of the author, and now it is basking in the sunshine of its eighteenth edition, published in 1913, an unprecedented period of sixty years. There seems to be no reason why its popularity should not continue as long as anatomy is taught. Another book, less frequently seen, was *Ellis' Demonstrations of Anatomy*. The author was Professor of Anatomy in University College, London. This book was deemed to be indispensable for the higher examinations in anatomy, those, for example, at the London University. So excellent did this book prove for its purpose that surprise can only be felt that the publishers should have made no effort, after the death of the author, to prevent it from lapsing.

Of physiology, then an unprogressive science, with a great future before it, there is not much to be said. Mr. Morant Baker was the lecturer, and naturally *Kirke's Handbook*, which he edited, was available for the purpose The numerous editions, however, through which it has passed show that it has enjoyed a popularity beyond the purlieus of Bart.'s. It gained a firm hold upon students from the beginning, inasmuch as for many years it was the only text-book on physiology provided for their use, and its popularity is still being maintained under the guiding hand of Professor Halliburton, of King's College.

A small but very popular manual on Elementary Physiology was that by Professor Huxley. It enjoyed a great vogue as an introduction to the science. To students, however, it was scarcely comprehensive enough for examinational purposes, and was only rarely seen in the school.

A short digression may here, perhaps, be permissible in order to call attention to a curious report, current among the students, in respect to the Lectureship on Physiology. At the time of the appointment of Mr. Morant Baker, Professor Huxley was a candidate for the post. Here, then, we are confronted with the fact that the most noted physiologist in th country, one whose reputation was world-wide, one whose pre-eminence as a teacher was universally recognised —an alumnus who had conferred honour upon the school—was rejected for the appointment of Lecturer on Physiology at Bart.'s. Of course there was a reason for this somewhat incomprehensible decision of the school authorities. But while to us in these days that reason would afford a subject for ridicule, it is necessary to remember the peculiar circumstances of the time at which his rejection was recorded. Just prior to the early seventies the acute stage had been reached of the controversy between science and religion. The public mind had become agitated upon the question. The tendency, it was held, of the advances of science was to lead to what was called materialism. Scientific workers were revealing problems, startling in their comprehensive development, altogether transcending anything which had hitherto come within the sphere of human knowledge. Here was held to be a source of danger, a danger the evil of which was clearly manifested in the scientists themselves. Becoming elated with their discoveries, so it was believed, they began to propound a materialistic doctrine, and Huxley and Tyndall were the chief of those concerned in this regard. Their views, openly expressed, disturbed the public conscience; the feeling was that they were harmful to religious orthodoxy, and even constituted a menace to the national life. In short, the conviction became generally prevalent that science, carried to its extreme limits, would ultimately usurp and destroy the authority of the Bible. In keeping with this impression, Huxley introduced the term, and labelled himself, an "Agnostic." The position he assumed, as such, frequently exposed him to vehement attacks, and upon science, as a whole, was laid the blame for his hostile controversial attitude, and the methods he employed for defending himself. That was the position when Huxley was rejected for the post of Lecturer on Physiology at Bart.'s. His views were regarded as being probably unacceptable to the parents of intending students, and as likely to imperil the reputation of the school. Looking back through the years that have passed, this controversial warfare of the early seventies is reminiscent of a nine days' wonder.* For subsequently it began to appear obvious that the more science advanced the wiser the world became, and with this added wisdom there followed the realisation of the great value of scientific discovery. Thus the alarms of materialism ceased under the enlightened conviction that between science and religion there could be no antagonism.

But a new era in physiology began in 1875 by the appearance of a translation of a work by the Professor of Physiology at the University of Zurich, Professor Hermann. The late Dr. Arthur Gamgee, of Owen's College, was responsible for the translation, and he tells us in his preface why he undertook the task. "I was actuated," he writes, "by the conviction shared in by nearly all teachers, that an urgent need existed for an English text-book which should represent the actual state of the science. It appeared to me, at the same time, that no text-book on physiology existed in any European language at once so concise, comprehensive and philosophical as the work which I now introduce to the English reader." Truly the book was a

* Huxley's last statement upon the subject appears in a lengthy and somewhat satirical article published in the *Nineteenth Century* for February, 1889.

fascinating revelation of the science; the light it shed upon old-time physiology revealed a new world of knowledge. However, it was barely a student's book, its science was too new and elaborate. Coming, as it did, like a bomb into the still waters of physiological teaching in this country, it almost created a sensation. My copy was bought for the purposes of the first Fellowship, for rumours "gathered and spread" that one of the examiners in physiology had adopted the plan of reading up some pages of Hermann, and testing the candidates' knowledge by means of them. Curiously enough, the translation never passed into a second edition, despite its attractive value, and now the book must be entirely forgotten. In general medicine a wider scope existed for the choice of text-books. Two, however, were mostly favoured, those by Dr. F. T. Roberts and the late Dr. Bristowe respectively. Both were bulky; the former, later, emerged into two volumes, and the latter possessed an examinational interest, inasmuch as the author was one of the examiners in medicine at the College of Surgeons. Some years ago each of these popular and excellent text-books passed into the reserve, and are not likely to be recalled for active service. Another book was also in vogue, but copies were difficult to obtain—*Tanner's Clinical Medicine*. The book was a small one, and proved to be especially useful, but it was out of print owing to the author's death. Nevertheless, it was greatly in demand, so much so that available copies changed hands at the price of 30*s*., the publishing price being 7*s*. 6*d*. Some students again found time to indulge in *Trousseau's Lectures on Clinical Medicine*, issued by the New Sydenham Society. These lectures at the time were universally held in high esteem, and were often quoted. But now in the far and distant past they have faded out of sight and knowledge, while during the zenith of their popularity they reached a pinnacle of greatness, forming a beacon guide by which many sought to secure pearls of illuminative wisdom. *Sic transit gloria mundi.*

Even in these days it may be asked, "What has become of *Quain's Dictionary of Medicine?*" A very fat volume on its first appearance, with a weak back which, through use, soon became broken. It proved a success; in later editions it blossomed forth into two volumes. Unhappily, however, its success was the cause of its undoing. The idea it suggested was soon appropriated. At various intervals since, numerous competitors have appealed for similar support, thus modern bookshelves are called upon to provide space for dictionaries, medical and surgical, encyclopædias, indices of treatment and of practice, some of these with a regiment of volumes, while others, confined within the limits of a single volume, are more adapted in price for the student's purse.

In the seventies, surgery, in the form of a text-book, was mostly represented by Erichsen's work, in two volumes. This work passed through several editions and was generally regarded as the best reflex of British surgery throughout the world. Its end, however, came with the ninth edition, thoroughly brought up-to-date, published in 1888. A curious criticism used to be repeated, in regard to this *magnum opus* of Erichsen. "What," it was once asked by a hospital surgeon, "can Erichsen know of surgery, when he has only twenty beds at his hospital?" Another book was noticeable among the less ambituous students, namely, *Druitt's Vade Mecum*. This was a stout little volume which, in 1870, had reached its tenth edition. But the profitable field of surgical text-books was destined soon to be invaded, and the first competitor was *Practical Surgery*, by Mr. Thomas Bryant, of Guy's. The success immediately acquired by this work was well deserved. Based upon the long and proved experience of a hospital surgeon and teacher, new editions were rapidly called for; then came another work, *The Principles and Practice of Surgery*, by Mr. Timothy Holmes, of St. George's. This tended to dim from the popularity it gained, the glamour of Mr. Bryant's work. Dressers almost exclusively favoured *Heath's Minor Surgery*, which still survives. Students at this time heard much also of *Billroth's Surgery*, another product of the New Sydenham Society in two volumes. It commanded notice because of the advanced scientific views of the author. As such, the volumes were recognised as useful for the higher surgical examinations, those in which degrees were concerned. In pathology there was only one book, known as *Green's Pathology and Morbid Anatomy*. It was small and handy, and otherwise conveniently and pleasantly supplied the student's requirements. Its second edition was issued in 1873, and it still survives, much enlarged and under new control. Of the same size, and belonging to the same series, was the sole eye book, that by Mr. Lawson, of the Middlesex Hospital. At that time the student had no choice, and it was not until *Nettleship* appeared on the scene in 1879 that another eye book became available. This proved a marked success, and in time reached its sixth edition. Each of these small books have long since lapsed into the unknown, despite the value of their teaching. In later years the eye student has been confronted with an *embarras de richesses* of text-books competing for his kindly favour. This special class of medical literature has greatly expanded of late. The results, however, judging from the demand, do not seem in most cases to have been directly encouraging to the authors, notwithstanding the reputation the latter enjoy in the ophthalmic world. Presumably of such books there are now too many, the field being overstocked to allow of any conspicuous success, with, perhaps, one exception.

And so from the above observations a reflection emerges, arresting in the conviction of its unassailable truth: What "classics" in medicine have passed into the dismal chamber of oblivion? Can such classics be held even now to be useless, centred, as they may be, around the science of the past? Can that suggestive work, *Hilton on Rest and*

Pain, long ago dead, be unworthy of perusal in this century? Let anyone read it and try afterwards to persuade himself that this question can be answered in the affirmative. But these classics often contain many pearls of wisdom, apart from their out-of-date scientific teaching, such wisdom being the special product of thoughtful minds. Science is ever advancing with the progress of time, but minds trained by observation and experience, manifestly exhibiting exceptional power, have often proved to be in advance of their generation. The wisdom, therefore, of a classic nevertheless valuable is apt to be lost and forgotten, submerged amid the all-pervading attractiveness of modern scientific discovery. The fault lies in the rush and hustle of the times, restricting our opportunities to wade through the tomes of the past. Our energies must be centred in the present; the claims of the present are urgent, inexorable, and always increasing, and so the classics of the past, despite their pre-eminence in the days of their popularity, and notwithstanding the greatness which still remains to them, fall by the way, overwhelmed by the demands of which each generation becomes the active source. Thus reaching their inevitable doom—they fade imperceptibly, irrevocably, into the gloomy, inglorious shade of obscurity.

CORRESPONDENCE.

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

DEAR SIR,—The reference to Skey's lectures in recent letters induces me to tell you of a lecture given by him on June 7th, 1870, of which I have my notes before me.

It was on burns, and the two chief points impressed on my mind (which without notes I could never forget) were:

(1) That he described carron oil as "that rascally compound."

(2) That the treatment he advised for burns was a strong solution of nitrate of silver to be washed over the burn; and, he added, the more pain caused by this application, the better for the patient and the quicker the relief!!!

At this lecture by Skey there was no rowdy behaviour nor excitement of any kind.

I must add a personal incident about Savory. This occurred in 1873, when I was in for the final College of Surgeons examination. Savory was the *bête noir* of candidates, and was feared almost as much by his co-examiners. I was being examined by Smith, of St. Mary's, who was a ponderous gentleman with a long beard. He examined me on diseases of the testicle and then went on to the bladder, and, after various questions, he asked me if cancer of the bladder could be felt through the abdominal wall. I did not know more than the man in the moon, and I hazarded a reply, "Yes." To which Smith promptly objected. Whereupon Savory, who was marking, turned to him, and in the suavest manner said: "Why, Mr. Smith, it was only last week I was called to see a patient at Hounslow with cancer of the bladder, and I could distinctly feel it through the abdominal wall." Mr. Smith never said a word, as he would not dare to disagree with Savory. As in 99 cases out of 100 of cancer of the bladder Smith would be right, Savory's intervention was very welcome.

Yours truly,
JAMES ADAMS.

4, CHISWICK PLACE, EASTBOURNE,
June 21st, 1916.

EXAMINATIONS.

UNIVERSITY OF LONDON.

Third M.B., B.S. Examination. May, 1916.

Group I. Medicine.—E. C. Spaar.

Group II. Surgery and Midwifery.—R. M. Dannatt.

L.S.A.

The Diploma of the Society of Apothecaries has been granted to E. G. D. Murray.

NEW ADDRESSES.

H. M. GREY, Fir Vale Hospital, Sheffield.
F. LLOYD HOPWOOD, Janefield, Aberdour, Fife.
E. W. J. LADELL, Eiffel Flats, S. Rhodesia.

APPOINTMENT.

J. WILMOT ADAMS, M.B., B.C.Cantab., appointed Lieutenant, Singapore Field Ambulance Company, whilst acting as Surgical Specialist to the Troops in the Singapore Garrison.

MARRIAGES.

CROWTHER—WOODLEY.—On June 14th, at Emmanuel Church, Plymouth, by the Rev. G. B. Berry, assisted by the Rev. Dr. Flynn, Capt. Charles Rowland Crowther, R.A.M.C., son of the late James Addington Crowther, of Bryn Tirion, Mannamead, Plymouth, to Kathleen Olive Mary, daughter of the late George W. A. Woodley, of Stonehenge, Natal, and niece of Mr. and Mrs. Woodley, of Evadne, Mannamead, Plymouth.

FRASER—BAILEY.—On June 13th, at Golden Hill Parish Church, by the Rev. J. H. Bailey, Vicar of Norton, Letchworth, brother of the bride, and Canon Hughes, Rector of Tarporley, Capt. Forbes Fraser, F.R.C.S., R.A.M.C., of Bath, to Agnes Mary, daughter of the Rev. G. R. Bailey, Vicar of Golden Hill and Rural Dean of Newcastle, and Mrs. Bailey.

PAVEY-SMITH—NORTHWOOD.—On June 3rd, at St. James's, Camberwell, by special licence, A. Bernard Pavey-Smith, Capt., R.A.M.C. (T.), younger son of Mr. and Mrs. A. E. Smith, of The Hollies, Nailsworth, to Elizabeth, youngest daughter of Mr. and Mrs. Northwood, of Spondon, Derby.

DEATHS.

KIMBELL.—On May 28th, at a Nursing Home in London, Lieut. Harry John Sullings Kimbell, R.A.M.C., of Richmond Road, Hackney, until recently in charge of Preston Hall Hospital, Maidstone.

PRESTON.—On June 2nd, through an accident to his car, Francis Harrison Preston, M.R.C.S., L.S.A., of The Grove, Brill, Bucks.

ACKNOWLEDGMENTS.

The Hospital, Long Island Medical Journal, New York State Journal of Medicine, Guy's Hospital Gazette, The British Journal of Nursing, The Nursing Times, The Medical Review, St. Mary's Hospital Gazette.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, 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 ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

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St. Bartholomew's Hospital Journal.

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

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CALENDAR.

Tues., Aug. 1.—Dr. Drysdale on duty.
Fri., ,, 4.—Dr. Tooth and Mr. Bailey on duty.
Tues., ,, 8.—Dr. Garrod on duty.
Fri., ,, 11.—Dr. Calvert and Mr. D'Arcy Power on duty.
Tues., ,, 15.—Dr. Morley Fletcher on duty.
Fri., ,, 18.—Dr. Drysdale and Mr. Waring on duty.
Tues., ,, 22.—Dr. Tooth on duty.
Fri., ,, 25.—Dr. Garrod and Mr. McAdam Eccles on duty.
Tues., ,, 29.—Dr. Calvert on duty.
Fri., Sept. 1.—Dr. Morley Fletcher and Mr. Bailey on duty.
Tues., ,, 5.—Dr. Drysdale on duty.

EDITORIAL NOTES.

COLONEL TOOTH has gone to Malta in the capacity of Consulting Physician to the Expeditionary Forces. Major Harnill has also left for Malta. We wish them both the best of luck while they are away from us.

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At a meeting of the Royal College of Surgeons held on July 14th, Mr. D'Arcy Power was elected a member of the Executive Committee of the Imperial Cancer Research Fund.

* * *

At the Annual Meeting of the Medico-Legal Society, Dr. Robert Armstrong-Jones was elected a Vice-President.

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The Military Cross has been awarded to Capt. R. S. Townsend, I.M.S., and to Temp. Lieut. C. C. Okell, R.A.M.C. Our heartest congratulations are extended to both.

* * *

It is with very much regret that we have to announce the death of Captain Robert Williams Michell, M.D., F.R.C.S., R.A.M.C., æt. 56. He was educated at Caius College, Cambridge, and St. Bartholomew's Hospital. He served through the South African War, gaining the Queen's medal with three clasps, and he volunteered again immediately on the outbreak of the present war. He was first appointed to the hospital ship "Asturias," and was on board when she was attacked by a submarine. Since May, 1915, he had been attached to the heavy guns, and he was fatally wounded on July 3rd. After helping a neighbouring medical officer who was in great difficulties, he organised and led a rescue party to bring in wounded men who had been lying out in "No Man's Land" for two days. Although wounded himself he continued his work for some hours, until he was struck a second time and paralysed. Our deepest sympathy is extended to his widow and only son.

* * *

We have also to record with much sorrow the death of Captain George Oliver Maw, R.A.M.C., who died of wounds on July 10th. He was educated at Clifton and Pembroke College, Cambridge, and completed his medical training at this Hospital. Our deepest sympathy is extended to Dr. and Mrs. Maw in their bereavement.

* * *

With much sorrow we also learn of the death of Lieut. Walton R. Wilson, R.A.M.C., who died on July 12th of wounds received the previous day. He was educated at Epsom College and Emmanuel College, Cambridge, and completed his medical training at this Hospital. Lieut. Wilson was married so recently as last April, and our heartfelt sympathy is extended to his young widow.

* * *

We very much regret to hear that Private Leonard Lovell, of the Canadian Infantry, was killed in action on July 11th. He was the son of Mr. John C. Lovell, one of the governors of this Hospital, and until recently one of its Almoners, to whom our deepest sympathy is extended.

* * *

As we go to press we learn with very much sorrow of the death of Lieutenant Stanley Walter Burrell, R.A.M.C., who died in France of cerebro-spinal meningitis on July 22nd. He was the second son of the Rev. F. W. Isaacs, vicar of Chiswick, having taken the old Yorkshire family name of Burrell shortly after qualifying. He was educated at St. Paul's School and St. Bartholomew's Hospital, where he gained the Warham prize for surgery. He threw himself whole-heartedly into whatever he undertook, and although in one of his last letters he said, "I never knew before what it means to work till one drops," his cheerfulness and keen sense of duty never faltered. Our deepest sympathy is extended to his parents in their bereavement.

* * *

At the same time we also hear with great regret of the death of Captain R. M. Dennys, who held a commission in the Loyal North Lancashire Regiment. He died from wounds received in action on July 12th. Our deepest sympathy is extended to Mr. and Mrs. E. A. Dennys and his many friends.

FROM THE FRONT.

EXTRACT OF A LETTER FROM DR. ANTHONY FEILING IN MESOPOTAMIA.

SOME time ago, while I was still enjoying the flesh-pots of civilisation in Alexandria, I wrote to Stansfeld, but the holiday which I was then enjoying has come to an end. We foresaw Mesopotamia when rumours began to percolate to Egypt that things were not quite what they might have been in the way of "medical comforts"! So we left Alexandria on March 19th with orders to report ourselves at "X——." We trained to Suez—a tedious and hot all-night journey—and embarked there on board the "B——," a P. and O. Hospital ship. We had a most delightful voyage round to the Persian Gulf, stopping only at Aden for twenty-four hours to coal. Aden is a singularly torrid and unwholesome place. We reached "Z——" in the Gulf on the fourteenth day out, and there had to lie to for nearly a week, in order to be transhipped to a boat shallow enough to pass over the bar of the river. The process of transhipping was much hindered by a violent gale, but we finally got off and came up to "X——" all right, arriving there on April 9th. The lower reaches of the Shat-el-Arab are rather picturesque—giving one an entirely erroneous impression of the country—as the river is about half a mile wide and fringed on each side by deep groves of date-palms—outside these nothing but bare desert, then still very swampy. "X——" is quite an interesting place for a few days, but awfully hot and steamy. Such town as there is is built on creeks, which run up from the river and cut the whole place up into little islands. One moves about entirely by water in belunis, a sort of enlarged Canadian canoe, but inferior and smaller than a gondola. As soon as we reached "X——" the inevitable happened, viz. our unit was at once broken up, and officers sent flying in all directions, some straight back to Bombay on hospital ships—these were the lucky ones. I was detailed for temporary duty at one of the existing hospitals, where I had charge of all the medical cases in the officers' hospital. The building had been the Turkish Governor's house, and ran to electric light, so we did pretty well. I had just settled down and got to know the men in the mess, when fresh orders came for me to "proceed" up the Tigris to a place on the line of communication, 140 miles above "X——." The voyage up, which took exactly three whole days, was most amusing, and certainly gave me a vivid idea of the difficulties of transport in this country. We were on an old stern paddle-wheel river-boat, converted into a hospital ship (so-called). She drew only 2½ feet of water, and was very top-heavy, consequently the combined effect of the wind and the current, which is anything from 4½ to 5 knots an hour, was too much for her, and she was blown about in the most absurd way. We spent a good deal of time drifting rapidly downstream broadside on. And one day we ran unusually hard into the bank, and had to lie there till the next morning! However, all good things come to an end, even voyages on the Tigris, and we eventually arrived one Sabbath morning. I was immediately attached to the hospital for duty, and have remained here, luckily for me, as it is certainly the best hospital here, and this place has the reputation of being the best place in Lower Mesopotamia—though that is saying but little! The hospital is placed right on the bank of the river, which rolls down a rapid, muddy stream, the colour of *café au lait*. This, I may add, is the sole supply of water for all purposes. At first, to my horror and consternation, I was put on to surgical wards, full of fractured femurs and skulls, secondary hæmorrhages, etc. Mercifully I was soon transferred to the charge of the medical wards, 120 beds in all, in huts. There is just enough to do to keep me amused. This is really a most God-forsaken country. No trees, no roads, nothing but the desert and the Tigris. It has become infernally hot, too; 108° in my tent at midday yesterday, and that is an Indian tent with a thick double roof with air space. Flies and mosquitos are a perfect pest, to say nothing of scorpions and hornets. Considering the country we do very well in the way of messing, though drinks are expensive, and apt to run out entirely at times. No ice, unfortunately, though we are promised an ice factory soon. I have kept quite fit in spite of a bout of the usual Tigris diarrhœa, which everyone has sooner or later. There is a lot of sickness, of course, chiefly typhoid, paratyphoid, and malaria, and diarrhœas of sorts, including *cholera*, of which I have had about ten cases, luckily not of a very acute type.

Last week I had to give four lectures to the whole of the troops of the station on the subject, delivered in the Y.M.C.A. in the "popular" style; they were quite well patronised. The fall of Kut was naturally rather a blow to us out here, but it was not unexpected. Now things seem rather at a deadlock, except for rumours of Arab raids. We have had a few sick from Kut, bags of skin and bone merely. I see great talk in the papers about the breakdown of medical arrangements here. With the material provided I think personally the R.A.M.C. have done very well, but there was a most appalling lack of decent supplies. Transport has been the difficulty, and the same ships which take up live sheep, mules, ammunition, etc., to the front, have had to bring down the sick and wounded.

DREAMS AND THEIR INTERPRETATION.

(*An Address to the Abernethian Society.*)

By Robert Armstrong-Jones, M.D., F.R.C.P.Lond., F.R.C.S.Eng.,

Lecturer on Mental Diseases, St. Bartholomew's Hospital, and Consulting Physician in Mental Diseases to the Military Forces in London; Resident Physician and Superintendent of the London County Asylum, Claybury.

THIS is the third time that I have been honoured by the Executive Committee of the venerable Abernethian Society, founded 1795, to address its members and visitors. Upon the first occasion we discussed the question of Temperaments, on the second the relationship of Genius and Insanity, and on this I have been requested to bring before you the subject of Dreams. John Abernethy (1764–1831), whom this Society commemorates, was no dreamer—although Sir James Paget described him as naturally indolent—and he never disdained facts which were within the range of physiological and anatomical experience. He possessed in no small degree a vivid and attractive power of exposition, as was testified by a great and appreciative audience of St. Bartholomew's men who crowded to hear his lectures at his house in Bartholomew Close.

It may seem out of place, whilst we are face to face with so grim a reality as war, which has affected us here at St. Bartholomew's (there are 1400 Bartholomew's men serving) as much if not more than any other institution or industry, that we should be discussing the realms of the unconscious, but we can claim that such a discussion is a relief to the strain and stress of reality, and that the "Bowmen" in the early days of the war laid particular emphasis upon dreams of the "Angels of Mons." Moreover, dreams have been regarded as one of the strongest forces wherewith to unravel the mysteries of the unconscious mind, and it is claimed that their interpretation may bring out of the unconscious mind what is perplexing and hidden, and may restore the balance in an unstable and wandering mind.

The laboratory of the mind is open to all, and I see before me some who are apt students in the field of mental exploration, those who have recently had special opportunities for probing into this dark territory. I also see others (among whom is the able nursing staff of St. Bartholomew's) who take an academic interest in the subject, but who nevertheless are justified in seeking for explanations in regard to facts which are within the experience of all.

The subject of dreams has interested mankind since the earliest days of primitive culture, and long before the dawn of history. Many and varied have been the speculations in regard to them, and the philosophers of antiquity entertained great diversities of opinion as to their cause and meaning. Dreams may be said to have a world of their own, and to have no links of connection with any other facts in human experience. The savage regarded the dream-world as similar to, only more remote than, the one he dwelt in. When he fell asleep his second self left his body for unfamiliar haunts, where he met the second self of his dead ancestors. Socrates believed in the divine origin of dreams. Lucretius accounted for them on the principle that ideas or thoughts were material things which could be detached from each other and be made to strike upon the mind. Porphyry ascribed dreams to the influence of a good demon who warned the dreamer of the evil the bad demon was preparing for him. Baxter, in his work upon the soul, attributed dreams to the agency of good spirits which descended from their proper sphere and condescended to weave midnight vision for poor mortals! As sleep has something awe-inspiring and inexplicable, so dreams viewed from the waking state have no less strange or perplexing a reality.

Dreams have been defined as "conscious processes during sleep" a definition which implies a self-contradiction, for conscious processes deny sleep, and normal sleep is attended with unconsciousness; but this unconsciousness may indeed be slight, yet it is not infrequently profound and even complete. During deep sleep the senses are unaffected by external and even by internal impressions, yet it has been asserted that the mind is never at rest during sleep, and that there is always some dreaming. Dreams have also been defined as thoughts, or a series of thoughts, experienced in sleep—*i. e.* a train of ideas presenting themselves to the mind during sleep. To-day the definition of a dream is "the symbol of an unfulfilled wish," the meaning of the symbol having to be interpreted by an assumed psycho-analytic "code"; and because of its symbolic function a dream is looked upon to-day as having its root firmly fixed in the experience of the waking life, whilst its superstructure lies in the unreality of phantasms It may help us to understand the terms symbol and symbolism if we state that they

are only applicable when the dream is interpreted, *i. e.* the dream then becomes the symbol of the meaning elicited. The terms themselves apply to the dream as recorded, or the manifest dream, which is always centralised round certain subjects connected with the waking experience, and not, as erroneously believed by some, always and invariably connected with sexual matters.

The history of dreams is a long and ancient record, and authorities in the past have offered many explanations as to the process and import of dreaming. The Old Testament describes many dreams, also their interpretation. We have the beautiful dream of Jacob's ladder, and that of Joseph, which he related to his brothers, also the dream of Pharaoh and of Pharaoh's servants, of Solomon's choice of wisdom, through which he obtained in addition riches and honour. The dream of Nebuchadnezzar, which, as frequently happens, he himself had forgotten, was, with Daniel's help, revealed and subsequently interpreted, often the quickest way then to royal favour, and in acknowledgment of which the "king made Daniel a great man." The influence of dreaming upon the conscience is shown by the dream of Job, when he affirmed that "God speaketh once, twice; yet man perceiveth it not." "In a dream, in a vision of the night when deep sleep fell upon man and sealed his instruction, He withdraws man from his purpose." In the New Testament there is Joseph's dream, both before and after the birth of the Saviour; the dream of the three wise men, and the dream of Pilate's wife, which were all quoted as messages from the spiritual world. Shakespeare puts into the mouth of Mercutio the cause of dreams: "Which are the idle children of a brain, begot of nothing but a fantasy." Byron, Milton, Robert Louis Stevenson, who stated that the motives for his best romances were inspired by dreams, Coleridge, Moore, and John Bunyan have all dwelt upon this attractive subject, and Bunyan stated that the whole of the *Pilgrim's Progress* was revealed to him in dreams. Certain races, like the North American Indians, are stated to look upon a dream as a sacred event, being the most ordinary way in which the gods make known their will to man. In the *Journal of a Voyage to North America*, Charlevoix relates how an Indian dreamed he had his hand cut off, which occurred the next day. The poor still have their dream-books, and they often pay for the "meaning" of their dreams.

It may help to clear our conception of the working of a dream if we briefly state how the mind works normally in the waking state. All of us are brought up to observe certain conventionalities, and to regard with solicitude certain social laws and amenities; in consequence of which feelings of undue assuredness, aggression, and self-assertiveness are kept under or repressed; and out of regard for social customs certain tendencies or passions are also kept under control, a feeling of self-restraint and inhibition being thus exercised. All of us, who are properly brought up, look upon ourselves with a certain compulsion in regard to observing the courtesies, ceremonies, and conventions of life, and our conduct is formulated accordingly. These compulsions eventually become automatic restraints, and they tend to keep up the structure and wholesomeness of human society. They constitute the feelings of social obligation and of personal regard for others, and are based upon certain instincts which have emotional representations, such as fear, anger, joy, sorrow, love, hate, and disgust. When, let us say, an object is presented to one of the senses—for instance, to the sense of sight—all the unconscious feelings of restraint which have been instilled into us in youth and which in grown-up people act automatically, are applied to the object we have in view, and our conduct or reaction towards it varies accordingly; for our unconscious life is always acting in numberless and unsuspected ways upon our conscious mental life. Supposing, for example, that we were watching a lady at some social function who was wearing a green carnation—certain rays of light from this object impinge upon the retina, these are conveyed to the brain and there stimulate a mental picture, *i. e.* the outward form, figure, surrounding circumstances, time and place of the person are appreciated as an external object, which, when absent, may be restored as an image, a picture, or idea upon the cerebral cortex, so that, in the absence of the object, an impression of the lady can be revived in memory upon the mind, the person being "remembered" with all her attendant associations. The mind recalls the occasion either with pleasure, or perhaps with pain, and in idea the whole previous scene can be re-enacted, even to the recognition of personal charms, gestures, verbal movements, conversation, habits and ways; these are accompanied by their emotional reactions; all can be revived as representative images, so that the mind is not only able to cognise an object, and associate it with a definite feeling, and with all the voluntary movements, but the image itself, or the memory picture, may also be revived with all the accompaniments belonging to the original presentation. These three factors, viz. cognition, feeling, and will, are the invariable accompaniments of every mental process, whether an object is presented from without or its picture is experienced from within. The same analogy applies to presentations and representations referring to the organic sensations. In dreams these three factors tend to become dissociated, the will alone remains in abeyance, whilst the cognitive elements may be represented, either by themselves, or they may be grouped with others which are similar or dissimilar; the feelings may also be represented to the mind, and may either be painful or pleasurable. It is the will which refuses to act, and it is questionable whether a dream, once initiated, can ever be modified by the will, although some persons state that they are able to modify a dream, and that they have frequently done so whilst dreaming. The recollection of these dissociated elements

of a dream when recalled by the memory is often so weird, so striking, and so suggestive, that an attempt to interpret their meaning is inevitable, and the phenomena of dreams have thus become objects of conjecture, of curiosity, as well as of vivid interest. In consequence many persons have endeavoured to read into them some hidden meaning, whilst others regard them with heedless indifference, considering them to be only a confused and jumbled record of sleep memories unworthy of serious reflection. Possibly the truth in regard to dreams lies between these two extremes of undue scepticism and a too *facile* credence. It is difficult not to suspect a meaning in some dreams, as in the dream of Mrs. H—, whose husband went to New York on business. She dreamed one night that he was sleeping on the tenth floor of a hotel which took fire, and that he escaped with difficulty. The next morning, feeling very uneasy, she cabled asking how he was, when he replied: "Quite well and safe, but had a narrow escape last night, when the hotel was burnt down." The following, sent to me by Dr. Leonard Guthrie, relates the experience of a credible witness, E. W. M—, a distinguished scientist and F.R.S. In his own words he writes:

"When I lived in Canada the following incident occurred:—

"An Englishman and an American clubbed together to try to reach the Klondike gold field by the overland trail, *i. e.* by going due north from the prairies instead of following the usual course of crossing by the Canadian Pacific Railway to Vancouver, then taking steamer up the coast to Seattle, and crossing back over the mountains *viâ* White Horse Pass. After the pair had on their journey passed what the American judged to be the outposts of civilisation, he shot the Englishman while he lay asleep, tried to destroy his body by burning it, rifled his baggage, taking everything of value, and returned. When he was questioned as to what had become of his companion, he replied that he (the American) had become discouraged and had given up the expedition, but that the Englishman had pushed on. But there was an encampment of Indians close to the spot where the crime had been committed. The old chief saw two men come north and encamp; in the night he heard a shot, and next morning saw one man go south. He went to the camp, saw the body, and informed the nearest post of North-west Mounted Police. They trailed the murderer and arrested him before he could escape across the United States border. He was brought to Regina. Meanwhile the brother of the murdered man in England had a dream in which he saw his absent brother lying dead and bloody on the ground. He came down next morning very depressed, told his dream, and announced his intention of going straight out to Canada to see if anything had happened to his brother. He did so and arrived out as the trial of the murderer was progressing. He identified several articles in the possession of the murderer as the property of his late brother. The murderer was hanged at Regina."

Another dream of a prophetic nature, and relating to the assassination of Perceval, is recorded in the *Book of Days*, i, p. 617. I am further indebted to Dr. Guthrie for calling my attention to it. It was the dream of Mr. John Williams, of Sarrier House, near Redruth, in Cornwall. He died in 1841, and was described in the *Gentleman's Magazine* as a man of the highest integrity. On the night after the assassination, when the facts could not have been known to him by any ordinary means, he dreamt that he was in the Lobby of the House of Commons, although he had never been there in his life. He saw a short, small man enter, dressed in a blue coat and a white waistcoat. Immediately after him entered another man in a brown coat with yellow buttons. The latter drew out a pistol and shot the former, who instantly fell, blood pouring from a wound a little below the left breast. In his dream Mr. Williams heard the report of the pistol, saw the blood flow out and stain the waistcoat, and he noticed the colour of the victim's face change. He further saw the murderer seized, and observed his countenance. When asking, in the dream, who had been shot, he was told "the Chancellor"—Perceval was Chancellor of the Exchequer at the time. Mr. Williams then awoke and mentioned the matter to his wife, who made light of it. At her suggestion he went to sleep again, but dreamt the same dream a second time, and then a third. After this, between 1 and 2 a.m., he got up and dressed. In the forenoon of the next day he went to Falmouth and related his dream again to Mr. Tucker, of Tremanton Castle, and to his wife. Mr. Tucker replied that the description was like the Chancellor of the Exchequer Perceval, although Mr. Williams had never seen Perceval nor had anything to do with him. Just then the news of the assassination reached Truro, which was seven miles away. Six weeks after the event Mr. Williams went to London and to the House of Commons. He recognised the Lobby, the exact spot where Perceval fell; and the dress of both men in the dream corresponded precisely with those actually worn at the time. The extraordinary thing about this dream was that a minute account of it was published in the *Times*, another was given to Dr. Abercrombie, whilst Mr. Williams' grandson communicated an account drawn up from his grandfather's words. All these agreed in every detail with the first narrative of the dream recorded by Mr. Williams.

Whether we regard dreams as in any way prophetic or not, Andrew Lang has stated it is remarkable, when we consider the enormous number of dreams, that there are not more than occasional coincidences. The successes only are noted whilst the failures as to prophecy have been forgotten. It was, probably, through the effort to elicit some meaning from dream phenomena that the idea of a soul first arose, and that this soul could exist apart from the body and survive its dissolution. The phenomena of dreams, or "visions" as they were called, suggested, as stated, excursions of the soul into some distant regions which it

explored, and reported what it had experienced to the waking soul, so that if the dream were of the dead the soul was believed to have travelled to the regions of the dead, and, if of the living, then the soul had wandered into the society of other living souls, and had some message of importance to convey to the dreamer, if only it could be properly and adequately interpreted or explained. Thus they were "symbols" of some message to be imparted by a supernatural being, *i. e.* if the dream could be properly solved. This "symbolical" view has been revived to-day, although the symbols are erroneously interpreted to be those of sexual disturbances. The interpreter of dream messages, or the "seer" as he was called in ancient times, was, naturally, a sacred person, who came to be regarded with considerable importance, if not with prophetic awe and as of divine origin. Thus arose the magician, or the "wise man," whose survival was formerly represented by uncultured and irresponsible fortune-tellers, but who are to-day represented, speaking generally, by competent and able psychologists, who, by methodically arranging and sorting the spontaneously uttered thoughts of a person who submits to examination, or by comparing the verbal association of a series of responses, ascertain the workings of the unconscious mind which lies beneath the manifest dream. According to the teachings of certain psychologists all thoughts and actions are assumed to be coloured by, if indeed they do not directly arise out of, the unconscious mind.

(*To be continued.*)

A CASE OF CEREBELLAR ABSCESS.

By J. SIMPSON WHITE, M.B., B.Ch.

I AM indebted to the courtesy of Mr. C. Ernest West for permission to publish the following case.

Patient J. M—, admitted to hospital on Monday afternoon, May 29th, with the following history: For five years has had discharge on and off from the left ear. For the past three weeks has suffered from pains in the head, giddiness, drowsiness, and frequent yawning. Three days ago these additional symptoms appeared: shivering fits (? rigors) and free perspiration. No vomiting; exceedingly deaf, had to be spoken to loudly.

Condition on admission.—Temperature 97° F., pulse 88. Covered with cold, clammy perspiration, furred tongue, drowsy, slow cerebration, took some time to answer questions, then spoke slowly as if he found it difficult to get the words he wanted. Headache was present, also pain over the occipital region. He vomited once. There was pendulum nystagmus to the left, slight exaggeration of the left knee-jerk, left ankle clonus, but normal plantar reflex; dysdiadokokinesis (left), a mitral systolic murmur at the apex conducted outwards. The spine was kyphotic, owing to old tubercular trouble.

A left radical mastoid operation was performed by Mr. Scott that same evening. The antrum was exposed and opened into; the bone was found to be very dense. The lateral sinus was then exposed and blood for pathological examination drawn off. (Result of examination: films showed no organisms. Culture sterile after two days.) The dura mater was not found exposed. A large cholesteatoma was discovered, which had made an opening into the labyrinth, destroying the ossicles. It had a very foul odour. The facial nerve had been laid bare for a considerable portion of its course. It was quite evident that left facial paralysis would inevitably follow such marked exposure of the nerve, and such was the case, the left side of the face being completely paralysed.

After this operation there was some slight elevation of temperature—99° F.—but it soon dropped again to subnormal, *i. e.* 97° F. There was also occasional slowing of the pulse-rate, 62 being the slowest rate. He indulged in sullen fits, sometimes refusing to be washed, also trying to get out of bed. His speech was still rather slow and laboured, but he did not complain of headache, nor did he vomit. Lumbar puncture was tried, but no cerebro-spinal fluid could be obtained.

This state of affairs went on until Thursday night, June 8th, when he vomited once or twice and complained of pains in the head. The temperature was still subnormal. On Friday morning his headache had got worse, also he could not raise his head from the pillow without the assistance of his hand. He vomited a few times during the morning. Examination showed a positive Kernig and nystagmus of an oscillating character to both sides; slight optic neuritis was also present. That afternoon Mr. West decided to operate.

Lumbar puncture was first tried, this time successfully. A test-tube full of clear fluid was drawn off. Then the wound of the previous operation was opened up. Landmarks were not easily discovered, the facial nerve not being visible at all now. The dura mater was incised and an expanding brain trocar was thrust into the lateral lobe of the cerebellum. Its blades were opened, with the result that pus immediately gushed forth. Fully 2 drachms were thus evacuated. The pus had a very foul odour. A drainage-tube, without any lateral openings, was inserted into the abscess cavity and secured firmly in position by means of a catgut suture. The edges of the skin wound were not sutured together. The drainage-tube protruded about the middle of the wound. The cavity around it was packed with gauze soaked in hypertonic saline solution. A small strip of gauze was also inserted into the tube. The wound was then dressed and bandaged in the usual manner.

After this second operation the temperature kept steadily down, never rising beyond normal. The pulse-rate again showed slowing at intervals, 60 being the lowest rate this time. He tried once or twice to tear off the bandage, and, for a short period, became somewhat unruly. Nystagmus was still present to both sides, and some occipital pain, which disappeared in a few days.

The wound was packed with gauze soaked in hypertonic saline solution every day, and the tube leading into the abscess cavity irrigated out, first with hydrogen peroxide, then hypertonic saline solution. This irrigation was accomplished by passing a tube of smaller diameter than the drainage-tube through the latter, and then letting the fluid run into the abscess cavity at a slow rate. At first there was a slight serous discharge from the abscess cavity, but this gradually ceased. Fourteen days after the operation the suture securing the tube in position was removed and the tube gently taken out for about $\frac{1}{4}$ of an inch of its length. This $\frac{1}{4}$ inch was then snipped off. The result of this was a small gush of pus. A few days afterwards the tube was again taken out another $\frac{1}{4}$ inch, and there was another slight gush of pus. Exactly three weeks after the operation, when dressing the wound, the tube came out altogether, having crept up unnoticed. It was not again replaced, but the small cavity still remaining was packed with hypertonic saline gauze.

Such is the condition of affairs at present, four weeks after the opening and draining of the abscess cavity. For the past few days he has been up and out in the hospital square. He is able to walk quite steadily, and the nystagmus has disappeared. He is quite bright and cheerful, and fully conscious of all he says and does. His only anxiety was to be allowed to smoke. The left facial paralysis is not noticeable to a casual observer. There is still some slight weakness in rotatory movements of the left forearm (left dysdiadokokinesis).

SIMPLE RHYMES FOR FRIGHTFUL TIMES.

No. 4.—CRUMPS.

When perhaps you've got the hump,
And a rather nasty crump
Makes a very horrid din
And spoils the dug-out you are in;
Then its price you calculate . . .
'Tis such things depreciate
The Hunnish *mark;* and much depress
The Hunnish people . . . *vide* Press.

J. R. R. T.

A CASE OF MALIGNANT ENDOCARDITIS GRAFTED ON A CONGENITAL SEPTAL DEFECT.

BY G. K. BOWES, M.R.C.S., L.R.C.P.

I AM indebted to Dr. Drysdale for his kindness in allowing me to publish the following case.

Considered as a whole the case is straightforward, and does not present any features of great rarity, but I regard its main interest as lying in the problem of differential diagnosis, to which it at one time gave rise. It also illustrates the value of pathological methods in deciding such a problem, for had it not been for the application of one of such methods, itself of quite recent origin, the diagnosis would have remained in doubt, and could not have been made by clinical methods alone till quite a late stage in the course of the case, and even then would have been uncertain.

W. P—, æt. 34, a clerk, was admitted to St. Bartholomew's Hospital on February 19th, 1916, complaining of abdominal pain and general weakness. The history of the case was as follows: Since he was an infant the patient was known to have had some affection of the heart, which, as there was no history of causative disease, was presumed to be congenital. This had caused him no trouble or inconvenience till the beginning of his present illness. He was last quite well in January, 1915; and from this time till July, 1915, he suffered from loss of appetite, langour, and occasional pains behind the eyes. He first consulted a doctor in August, 1915. At this time his temperature was raised, and he used to sweat profusely. He remained in bed for a few days. In September he became weaker, and was troubled by abdominal pain, which was localised around the umbilicus, and was worst about half an hour after food. He remained in bed for about three weeks and returned to work in the middle of November, still suffering from loss of appetite and abdominal pain. From the end of December till his admission to hospital he remained in bed most of the time. During the last three weeks before admission he vomited three or four times. During the period of this history he was suffering from fever when he was seen by his medical attendant.

On admission on February 19th the patient was pale and thin, his weight being 7 st. 11 lb. His temperature during the first three days ranged from 97·6° F. to 102° F., and his pulse-rate from 96 to 124. The eyes were natural and no retinal hæmorrhages were seen. On the chest and abdomen were large areas of pigmentation with scaly skin due to a skin infection. The lungs were natural. The heart showed a diffuse pulsation, most marked in the fifth interspace, about 4 in. from the middle line. On percussion it was found to be somewhat enlarged, the deep dulness extending $1\frac{1}{2}$ in.

from the middle line in the fourth space to the right, and 4¼ in. in the fifth space to the left of the middle line. A loud, harsh, systolic murmur was present, which was heard best over the fourth left costal cartilage, and propagated widely all over the front of the chest, but not outwards to the axilla. The second sound at the pulmonary base was slightly accentuated. The abdomen was somewhat distended, and there was some shifting dulness in the flanks. The liver was enlarged, extending 6¼ in. when measured vertically in the nipple line, its edge being palpable well below the costal margin. The spleen was also enlarged and tender, its edge being palpable 3 in. below the costal margin. There was no œdema of the legs. The urine contained ·1 per cent. of albumin and some blood. There were no superficial enlarged glands anywhere. A blood-count showed that the patient was anæmic, the number being:

Red cells	2,570,000 per c.mm.
Hæmoglobin	50 per cent.
Colour index	·97.
White cells	10,400 per c.mm.

The differential count showed:

Polymorphs, 73 per cent.	7600 per c.mm.
Lymphocytes, 25 per cent.	2600 ,,
Mononuclears, 2 per cent.	200 ,,
Eosinophiles, none seen.	
Basophiles, none seen.	

Slight poikilocytosis, anisocytosis, and polychromatophia were present; no abnormal white cells or nucleated red cells were seen.

At this stage the facts known about the patient may be summed up as follows: A congenital heart lesion, continued fever for six months, a slightly enlarged heart with a widely propagated systolic murmur, an enlarged liver and spleen, a high degree of anæmia with colour index ·97, and with 10,400 leucocytes per c.mm. It was thought probable that the heart murmur, taking into account its localisation and the absence of any other signs such as cyanosis or venous regurgitation in connection with it, might be due to an imperfect interventricular septum. At this stage of the possible diagnoses the two which seemed most probable were (*a*) Hodgkin's disease, and (*b*) malignant endocarditis grafted on a congenital heart lesion. It was impossible without further knowledge to decide between these two alternatives. Although the absence of superficial enlarged glands pointed against Hodgkin's disease, cases are known where only the internal glands have been enlarged, with an enlarged spleen and liver, and a blood-count and temperature chart not unlike those of the case under consideration. With the second alternative would agree the continued fever, the signs in the heart, and the enlarged liver and spleen, the enlargement being in this case due to back pressure and to septicæmia, and, in the case of the spleen, perhaps to infarction as well. Other possibilities were the following: Splenic anæmia, with which the high colour index of the blood and the high leucocyte count did not agree at all, nor did the fever well, which, although it may be present, is in this degree unusual; familial acholuric jaundice with enlarged liver and spleen, which would not explain the fever; and the possibility that the condition might be connected with syphilis. The length of the history, as well as the absence of characteristic symptoms, rendered typhoid fever very improbable.

To decide between these possibilities the following investigations were undertaken. A skiagram was taken to determine the presence or absence of enlarged glands in the chest. Some enlarged glands were seen to be present in the posterior mediastinum. The fragility of the corpuscles was investigated and found to be normal, thus excluding congenital acholuric jaundice. A culture made from the fæces showed that no abnormal members of the coli group were present, thus excluding typhoid. The Wassermann reaction was strongly positive. On February 23rd a blood-culture was made, and the blood was shown to contain large numbers of a streptococcus, giving the fermentative reactions of *Streptococcus salivarius*. The result of the blood-culture enabled the diagnosis to be made that the patient was suffering from malignant endocarditis.

A vaccine was prepared from the organism present in the blood. The first dose, consisting of five million organisms, was given on February 29th, and the vaccine repeated in increasing doses up to fifty million, the last being given on March 12th. From February 19th till 29th the temperature varied between 97·6° F. and 103° F., being several times over 102° F. The pulse-rate was frequent, up to 136. After March 2nd, when the second dose of vaccine was given, the temperature began to fall, and from that time onwards remained on a considerably lower plane, being only occasionally over 100° F., but the pulse-rate became rather more frequent, and the general condition of the patient became worse. A second blood-culture was made on March 21st, and showed a much smaller number of organisms. A vaccine was prepared from this possibly more resistant strain, and a single injection of twenty-five millions given on March 24th.

At the beginning of March a change was noticed in the condition of the heart murmur, this becoming softer in character. The patient complained at times of tenderness over the spleen. On March 29th he began to suffer from diarrhœa, and on March 31st began to pass a large amount of altered blood with the stools. It was thought at the time that he might have an intestinal infarct. On April 3rd the patient complained of pain in the left axilla. The percussion note was impaired in this situation, the breath sounds were feeble, and friction was heard. The sputum was blood-stained. These signs were thought to be due to a pulmonary infarct, and before death signs pointing to the presence of fluid were evident. The patient died on April 8th.

To complete the history I will mention the fact that the patient was on February 24th given potassium iodide in 5-gr. doses three times a day, and in all had 35 grs. This led to the appearance of an eruption, first bullous, then pustular, on the face and neck. This special susceptibility to iodides may have been connected with the septicæmic condition.

The post-mortem examination showed that the diagnosis made during life was correct in most particulars. The heart weighed 11 ozs. The right auricle was considerably dilated. Large verrucose vegetations were found projecting into the right auricle from the tricuspid valve, to which some ante-mortem, but recent, clot was adherent. On opening the right ventricle the tricuspid valve was found covered with a mass of verrucose vegetations, which extended to the ventricular walls, both septal and parietal; also both chordæ tendineæ and musculi papillares. On opening the left ventricle the mitral valve was found to be natural. Two of the aortic valves contained small vegetations attached to the corpora aurantii, and in one case the vegetations extended to the anterior aspect of the cusp. Beneath the septal aortic cusp there was an opening which communicated with the right ventricle. This was funnel-shaped, being larger at the left ventricular side and smaller at its opening into the right ventricle behind the septal cusp of the tricuspid. It was lined by what appeared to be a thickish white-coloured continuation of the endocardium. There were no vegetations on this, but a mass obscuring its opening into the right ventricle. With regard to the lungs and pleuræ, the right lung showed the remains of a small infarct at the hilum in the base of the upper lobe. The left plural cavity contained about a pint of blood-stained, turbid effusion, and there was some fibrinous pleurisy at the base posteriorly. The posterior part of the lung was found to be solid and greyish, with hæmorrhagic mottling and purulent exudation from the bronchioles. The intestines showed congestion, but no infarction. The liver showed evidence of chronic congestion and fatty degeneration, and was enlarged. The spleen was enlarged, soft, and congested, with perisplenitis, but no infarction. The kidneys showed red and yellow mottling, with many minute petechiæ on the cortex. Of these conditions one which requires further consideration is that of the white infarct of the lung. It is usually stated that, owing to the double blood supply, white infarcts do not occur in the lungs, but I think that in this case its occurrence may be explained by the fact that, when the infarct occurred a short time before death, the circulation was so feeble that the infarct passed from the condition of red to that of white infarction, as is the usual occurrence in organs with a single blood supply.

CHLOROFORM-ETHER ANÆSTHESIA.

By H. F. PARKER, M.D.(Cant.).

IT may be of sufficient general interest to call attention to a method of chloroform-ether anæsthesia which, though not new, is one that appears to be not as generally adopted as it deserves to be.

It consists simply in giving a mixture of chloroform and ether in suitable proportions from an ordinary Clover's inhaler, discarding the bag altogether.

The method of administration is as follows: A mixture of 1 vol. of chloroform to 2 vols. of ether is prepared. Some ℥iifs of this mixture having been poured into the chamber of the Clover, the patient is allowed a few breaths with the indicator standing at 0. The chamber is then slowly rotated until the indicator points to $3\frac{1}{2}$ or 4, and the latter is maintained at this point or thereabouts until the patient is ready for operation—usually a matter of some five to eight minutes. The indicator is then gradually moved back to approximately $1\frac{1}{2}$, which will suffice to keep the patient fully anæsthetised. In robust patients it may occasionally be necessary to put on the bag for a few breaths at the commencement. A fresh supply of the mixture will have to be added at the end of a quarter of an hour and subsequently about every half-hour.

The undoubted advantages of this method may be tabulated as follows:

(1) It is an open method. As no bag is used there is no re-breathing.

(2) The percentage of anæsthetic-vapour in the inspired air remains absolutely constant except in so far as the administrator desires to vary it; and this he can do with any degree of precision that he likes, his aim being to maintain the requisite degree of anæsthesia by the employment of a minimum quantity of anæsthetic.

(3) It is easy and simple in its mode of application. One hand is sufficient for holding the mask in place and for keeping up the jaw, thus leaving the other hand free for feeling the pulse, testing the lid-reflex, or for other purposes. The mask need not be removed from the face during the whole of the operation except momentarily for replenishing the chamber; in fact, under a light anæsthesia it is better not to remove it for more than a few seconds at a time, so as not to alter the proportion of vapour present in the alveoli of the lungs. In a prolonged operation it is a great relief to be able to dispense with the usual drop-bottle and lint face-piece. Moreover, the inhaler can be easily retained on the face, whatever position of the head may be required by the exigencies of the operation.

(4) The face is not completely covered, consequently the patient's colour—one of the most important points to observe in the giving of an anæsthetic—is always obvious.

(5) The mixture is not unpleasant to inhale—a point of some importance in the case of nervous patients.

The respiration is remarkably quiet and free from stertor, and there is little tendency to salivation.

(6) It is a safe method, for the reasons that will be obvious from a consideration of the above headings.

(7) It is economical as regards the consumption of anæsthetic, as there is no waste caused by needless evaporation.

(8) There is no danger of spilling anæsthetic upon the patient's face.

(9) In the event of a doctor being single-handed he can, after inducing anæsthesia by this method, set the indicator at a perfectly safe position—say $1\frac{1}{2}$—give the mask to a nurse to hold in place, instructing her to hold up the jaw and watch the patient's respiration.

In cases where scopolamine-morphia has been injected this same method seems perfectly satisfactory, though in such cases I usually use a proportion of 1 vol. chloroform to 3 of ether.

Ethyl chloride is an anæsthetic that is not now so much in vogue as previously, largely, I believe, because accidents happened in consequence of the use of inhalers of a closed type.

A convenient way of giving it consists in spraying some 5 c.c. into the chamber of a Clover's inhaler, and then rotating this—probably not much beyond the figure 1—until the requisite degree of anæsthesia is obtained.

RAHERE LODGE.

THE Installation Meeting of the Rahere Lodge, No. 2546, was held in the Great Hall of St. Bartholomew's Hospital on June 20th. The W.M., W. Bro. Anderson, initiated E. D. Whitehead Reid, and then installed W. Bro. W. J. Gow as W.M. for the ensuing year. The following officers were appointed :

W.Bro. C. H. PERRAM, P.P.G.W. Beds.	W.S.
W.Bro. A. HEPBURN, L.R.	J.W.
Bro. The Rev. H. S. CLOSE	Chaplain.
W.Bro. ERNEST CLARKE, P.M., P.G.D.	Treasurer.
W.Bro. E. LAMING EVANS, P.M., L.R.	Secretary.
W.Bro. T. G. A. BURNS, P.M., P.G.D.	D.C.
Bro. A. W. STOTT	S.D.
Bro. H. PRITCHARD	J.D.
W.Bro. M. L. TRECHMANN, P.M., L.R.	1st Asst. D.C.
W.Bro. H. MORLEY FLETCHER, P.M.	2nd Asst. D.C.
W.Bro. P. S. ABRAHAM, P.M., P.G.D.	Almoner.
Bro. NORMAN F. SMITH, Asst. G. O. Oxfordshire	Organist.
Bro. A. L. MORETON	Asst. Secretary.
Bro. B. T. LANG	I.G.
Bro. A. S. WOODWARK	Sen. Steward.
Bro. W. R. READ	Steward.
Bro. J. H. GRIFFITHS	Steward.
W.Bro. E. P. FURBER, P.P.G.J.W., Surrey	Steward.
Bro. W. G. BALL	Steward.
Bro. E. BURSTAL	Steward.
W.Bro. A. H. COUGHTREY	Tyler.
Bro. E. W. HALLETT	Asst. Tyler.

CORRESPONDENCE.

THE MERCANTILE MEDICAL SERVICE.

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

DEAR SIR,—At the present time, when every trade and profession is looking anxiously ahead, it is essential for the welfare of the medical profession that it in its turn does not fail to guard in so far as it can the interest of its members. It is seldom realised by the majority of medical men that a most necessary, useful and pleasant branch of the profession has its "dwelling upon the waters." I refer to the Mercantile Medical Service, which for many years has offered health-giving, instructing and entertaining work to medical men. Nevertheless at the present moment it is the most unsatisfactory and neglected branch of the medical profession. The reasons for this are (i) that medical men, regardless of the welfare of their sea-going brethren, take for their own pleasure or convenience nominal remunerations in permanent sea-going posts, and (ii) that it is a branch of the profession in which the drunkard, the morphiomaniac and the waster-in-general can usually find employment—the "dumping-ground," in fact, for the "professional degenerate."

Thus in the past the shipping companies have found it possible to provide medical men for their vessels without difficulty, and at a rate of pay inferior as a rule to that of their second mates! It is then incumbent upon us to secure an adequate remuneration for the ships' surgeons (i) by refusing to accept a permanent appointment at sea for a remuneration less than that necessary to support one of the regular sea-going medical men, and (ii) by insisting that those shipping companies which continue to employ the "medical degenerates" and "black-legs" for the sake of economy, are prevented from securing the services of other medical men. It is to the younger men of the profession that we must look for the necessary assistance in bringing about a long-needed change in the conditions of the Mercantile Medical Service, for it is in great part due to the past inconsideration and selfishness of the younger members that improvement has not already taken place.

In conclusion, may I suggest that the so-called "medical agents" be carefully avoided, and that eighteen guineas per month be regarded for the present as a *minimum* wage for the medical man at sea.

I am,
Yours faithfully,
L. T. RUTHERFORD, M.B.Cantab.

St. Thomas's Hospital,
London, S.E.,
June, 1916.

ROYAL MEDICAL BENEVOLENT FUND.

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

DEAR SIR,—The Royal Medical Benevolent Fund, the great Benevolent Society of the Medical Profession, is sorely in want of money now.

Though in ordinary times the medical profession supports its own poor, in these war times this is no longer possible. At the May meeting the Committee had a balance of only £17 in hand, and at the June meeting was faced with a deficit of £16. The demands were heavy and had to be met, and this could only be done by withdrawing £500 from the bank.

As the direct outcome of the war, not only are the ordinary cases of poverty greatly increased in number, but an entirely new class of case has arisen urgently requiring relief, in which without actual poverty there is great temporary distress—distress, however, which it is hoped will relieve itself soon after the war is over and the doctors serving return to their civil duties.

At the outbreak of war, the medical profession responded freely to the nation's call. The Territoral Medical Officers were at once called out, and other medical men volunteered. Both alike had to leave their practice at very short notice, and often without being able to make adequate provision for its continuance and maintenance during their absence. Their pay went but little way to supply the loss which their absence entailed, for the working expenses of the practice could not be materially reduced. The result was that many families found themselves in very straitened circumstances. Rent, rates and insurance brook no delay, but, worst of all, school bills could not be paid, and if help had not been quickly forthcoming the children would have suffered for the patriotism of their father.

The following are typical of the cases with which our Fund has had to deal:

A young doctor who had only been in practice a few years, volunteered for service, and was killed in action a few days later. He left a widow, æt. 35, with two young boys, æt. 3½ and 1 year, entirely without means. The Fund voted £25 for her immediate necessities, and put her into communication with the Officers' Families Association, which gave further help.

A practitioner, æt. 38, earning £700 to £800, volunteered for service, leaving his practice in the hands of a neighbour who was not a success. There were two young children, and another baby was born shortly after the husband left. The wife contracted pneumonia and nearly died. A resident patient had to leave the house. Rent and other expenses led to a debt of about £80. This the doctor could not meet, and he hurried back from the trenches to save his home from being sold up. The Fund voted £25, the Guild gave £15, the Officers' Families Association £25, and the Professional Classes War Relief Council further help, with the result that he returned to the Front with his immediate anxieties relieved.

A captain in the Territorials was called out and had to leave his practice in the hands of a *locum*, who proved a failure. There were seven children, æt. 2 to 14. Financial difficulties arose and payment of the school fees became impossible. Between the Fund and Guild and the Officers' Families Association the necessary fees were raised, and clothing, which was greatly required, provided.

These cases show well the way in which the Fund works, not only by giving relief itself in money and kind, but also by obtaining, through co-operation with other benevolent societies, more substantial assistance than it could afford alone.

But there is another class in which the distress is perhaps even greater, and adequate relief more difficult. It is that of men who left home and a good practice in vigorous health and who have come back, crippled by wounds or with health impaired, to a practice severely damaged by their absence, and without the strength or energy to regain the practice and position which they sacrificed.

Our Fund has set apart a special sum to meet emergency claims of this kind, yet the demands are so great that it will soon be exhausted. We cannot now rely on the profession alone to supplement it largely, for the medical profession, like all other professions, is hit very hard by the war and has no longer its old resources to draw upon.

What is required is an Emergency Fund large enough to deal adequately with these emergency cases arising directly out of the war, and for this we are driven to appeal to the public as well as to our own profession.

We trust that our appeal will meet with a liberal response both from the public and from the medical profession, for unless fresh funds are quickly forthcoming it will be impossible to continue the relief which is so urgently required.

We are, faithfully yours,
JOHN TWEEDY, *President.*
SAMUEL WEST, *Hon. Treasurer.*
G. NEWTON PITT, *Hon. Secretary.*

11, Chandos Street, Cavendish Square,
London, W.
July 3rd, 1916.

REVIEWS.

URINE EXAMINATION MADE EASY. By THOMAS CARRUTHERS. (J. & A. Churchill.) Third Edition. Price 1s. net.

A most excellent little book for nurses, and be it also said for students. The ordinary tests are set out clearly, and their exact technique is minutely explained, the reasons for the apparent failures of the various tests being given. The table at the end of the book giving the meaning of various phenomena is very useful, especially in so far as the colouring of urine due to drugs is concerned.

GRAY'S ANATOMY. Edited by R. HOWDEN. (Longmans, Green & Co.) Pp. 1304. Nineteenth Edition. Price 32s. net.

We are sorry to see this famous old work still clinging to the Basle terminology, in spite of the fact that this is not our official terminology and never likely to be in its present form. The student who attempts to use this work will be muddled by finding that the musculo-spiral nerve has become the radial nerve; he will then be taught by one of his demonstrators that the radial nerve supplies no muscles, and—we need not, however, beat a dead horse. Apart from the terminology, the new edition is all that may be desired; many new illustrations have replaced old ones, and the text is as it always has been, clear and concise. But when we try to read it, and then refer to a recent examination paper where the second question commenced, "Describe the musculo-spiral nerve," we feel that it would scarcely be our duty to recommend it to students, at any rate so long as there are other anatomy text-books on the market which adhere to the official nomenclature.

MANUAL OF OPERATIVE SURGERY. By J. F. BINNIE. (H. K. Lewis & Co., Ltd.) Pp. 1363. Seventh edition. Price 32s. net.

The regular appearance of new editions of this work speaks more than anything of its usefulness. It is a work which devotes itself principally to the less common and unusual operations in surgery. To quote from the Preface: "The constant endeavour has been to give aid to the surgeon when he is in trouble, hence much greater space has been devoted to some rather rare operations than to many . . . which ought to be familiar to everyone."

Thus there is an excellent chapter on cardiac surgery, and another on retro-peritoneal neoplasms, and a short chapter on war surgery has been added.

The work is invaluable to, and should be read by, all who are taking the higher examinations in surgery.

RADIUM X RAYS AND THE LIVING CELL. By H. A. COLWELL and S. RUSS. (G. Bell & Sons, Ltd.) Pp. 324. Price 12s. 6d. net.

An excellent little work dealing mainly with the chief experimental facts which have been established in regard to this subject. The early part of the work is devoted to a description of the properties of the radiation, while the latter portions deal in considerable detail with the actual microscopic alterations which take place in the various tissues, both healthy and diseased, under the influence of these rays. The illustrations and coloured plates are excellent, and the authors are to be complimented on a very complete little work.

ESSENTIALS OF HISTOLOGY. By Sir E. A. SCHÄFER. (Longmans, Green & Co.) Pp. 563. Tenth edition. Price 10s. 6d. net.

This almost historic text-book for students needs but little commendation at the hands of a reviewer. It is the *vade mecum* of many thousands and will probably remain so of years to come. In the present edition, which is somewhat larger than the last—alas poor student!—there has been a complete revision of the text and many additional illustrations appear, most of them being photographs of microscopic preparations. We can only continue to recommend a book which has already recommended itself to the majority.

EXAMINATIONS.

CONJOINT BOARD.

July, 1916.

First Examination.

Chemistry.—L. E. R. Carroll, J. A. Morton.

Physics.—L. E. R. Carroll, J. A. Morton.

Elementary Biology.—M. N. Eldin, E. D. Macmillan.

Practical Pharmacy.—L. E. R. Carroll, D. H. Cockell, B. Goldfoot, J. A. Morton, T. M. Payne, C. G. J. Rayner, E. J. G. Sargent, P. A. Smuts, T. B. Thomas.

Second Examination.

Anatomy and Physiology.—F. C. Cozens, E. Gallop, J. N. Leitch J. G. Williams.

Final Examination.

The following candidates have completed the examination for the Diplomas of M.R.C.S. and L.R.C.P.: T. B. Bailey, G. A. Beyers, W. H. Blackburn, E. G. P. Bousfield, C. V. Braimbridge, L. J. F. Bull, G. E. Burton, J. B. Flamer Caldera, P. N. Cook, W. R. Dickinson, D. D. Evans, J. J. Gasperine, J. B. Hume, T. Joekes, H. M. C. Macaulay, W. E. Wilson, H. M. Wharry.

UNIVERSITY OF CAMBRIDGE.

First M.B. Examination. June, 1916.

Part III. Elementary Biology.—A. Jephcott.

Second M.B. Examination. March and May, 1916.

Part II. Pharmacology and General Pathology.—B. F. W. Armitage, C. V. Braimbridge, G. E. Burton, A. J. Copeland, G. A. Fisher, E. G. D. Murray, E. D. Spackman, H. F. Squire.

Second M.B. Examination. June, 1916.

Part I. Human Anatomy and Physiology.—C. A. Horder, J. L. Potts.

Third M.B. Examination. June, 1916.

Part I. Surgery and Midwifery.—K. B. Bellwood, W. H. Blackburn, C. V. Braimbridge, A. Orr-Ewing, H. G. E. Williams.

Part II. Medicine, etc.—K. B. Bellwood.

UNIVERSITY OF LONDON.

M.S. Examination. July, 1916.

Branch I. Surgery.—A. L. Moreton.

Second Examination for Medical Degrees.

Part II. Pass List.—L. Handy, C. L. Hewer†, L. D. Porteous, E. S. Rose, V. A. T. Spong, N. B. Thomas.

† Dist. in Physiology.

APPOINTMENT.

MASTERMAN, E. W. G., M.D., F.R.C.S., D.P.H., Medical Superintendent (for the duration of the war) of St. Giles' Infirmary, Camberwell, *vice* W. C. Keats, resigned.

NEW ADDRESSES.

G. O. JACOBSEN, Wellington, New Zealand.
F. E. WHITEHEAD, Medical Officer, Berbera, B. Somaliland (*via* Aden).

BIRTHS.

BANGAY.—On June 26th, at Westlands, Warblington, Hants, the wife of Surgeon J. D. Bangay, R.N., H.M.S. "Antrim," of a son.

BLAKEWAY.—On July 1st, at 1, Weymouth Street, W., to Mr. and Mrs. Harry Blakeway, a daughter.

BREWERTON.—On June 25th, at 36, Portland Court, W., the wife of Elmore Brewerton, of 84, Wimpole Street, of a daughter.

FISON.—On June 18th, at Lawnswood, Wigmore, Chatham, the wife of James Fison, Surgeon, R.N., of twin sons.

HAY.—On June 17th, at 14, Vicarage Gardens, Kensington, W., the wife of Dr. K. R. Hay, of a daughter.

LEA-WILSON.—On June 20th, at the residence of her mother, 57, Beauchamp Avenue, Leamington Spa, the wife of Capt. B. Lea-Wilson, R.A.M.C., of a son.

O'CONNOR.—On May 29th, at 21, Alexandra Mansions, Chelsea, to Capt. F. W. O'Connor, R.A.M.C. (temporary), and Zella O'Connor, a daughter.

SIDGWICK.—On June 12th, at "Fircot," Ashby Parva, Lutterworth, the wife of Major Sidgwick, R.A.M.C., a daughter.

WAKEFORD.—On May 31st, at 728, Fulham Road, the wife of V. D. C. Wakeford, M.B., B.S., of a son.

MARRIAGES.

BRASH—BARNETT.—On July 7th, at St. Margaret's, Lee, Capt. E. J. Y. Brash, R.A.M.C., M.B. Camb., M.R.C.S., L.R.C.P. (Bart.'s and Camb.), son of E. A. Brash, M.R.C.S., L.R.C.P. (Bart.'s), of Exeter, to Gwendolene Barnett, third daughter of F. Septimus Barnett, M.R.C.S. (Bart.'s). Among those present were Burgess Barnett, M.R.C.S., L.R.C.P. 'House Physician (Bart.'s), and Mrs. Burgess Barnett, brother-in-law and sister of the bride.

CANE—PERKINS.—On July 24th, at St. John's, Meads, Eastbourne, by the Rev. John Salwey, Capt. Maurice H. Cane, R.A.M.C., third son of the late Leonard Cane, M.D., of Peterborough, and Mrs. Cane, of Eastbourne, to Marjorie Amy, second daughter of H. I. Perkins, I.S.O., F.R.G.S., F.G.S., Surveyor-General, British Honduras, and Mrs. Perkins, of Wimbledon Park, and granddaughter of Major-General E. Norman Perkins, Bengal Staff Corps.

DEATHS.

BURRELL.—On July 22nd, of cerebro-spinal meningitis, Lieut. Stanley Walter Burrell, R.A.M.C., M.R.C.S., L.R.C.P., of St. Bartholomew's Hospital, second and dearly loved son of the Rev. F. W. Isaacs, Vicar of Chiswick, and Mrs. Isaacs, aged 25. He took the old family name of Burrell on qualifying.

DENNYS.—On July 24th, in hospital, from wounds received in action on 12th inst., Capt. Richard Molesworth Dennys, M.R.C.S., L.R.C.P., Loyal North Lancashire Regt., dearly loved only son of Mr. and Mrs. E. A. Dennys, 125, Coleherne Court, S.W.

MAW.—On July 10th, from wounds received in action on the 9th, George Oliver Maw, Capt., R.A.M.C., son of Dr. and Mrs. Maw, Shortlands, Kent.

MICHELL.—On July 20th, of wounds received on July 3rd, Robert Williams Michell, M.D., F.R.C.S., Capt., R.A.M.C., of Brook House and 3, Trinity Street, Cambridge, dearly loved husband of Emily S. Michell, aged 56.

TREVAN.—On July 16th, at Pendrean, Salcombe Regis, Sidmouth, Frederick A. Trevan, late Staff Surgeon, R.N., and The Firs, Bideford, N. Devon.

WILSON.—On July 12th, died from wounds received the previous day, Walton Ronald Wilson, B.A.Cantab., M.R.C.S., L.R.C.P., Lieut. R.A.M.C., M.O. Seaforth Highlanders, only son of Dr. and Mrs. Wilson, Forest Hill, S.E., and dearly-loved husband of Emily Constance Wilson (*née* Mottershall), aged 25.

ACKNOWLEDGMENTS.

The Nursing Times, L'Attualita Medica, The British Journal of Nursing, New York State Journal of Medicine, Guy's Hospital Gazette, The Medical Review, St. Mary's Hospital Gazette, The Shield, The Middlesex Hospital Journal, The Hospital, The Medical Press and Circulator.

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 ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

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St. Bartholomew's Hospital Journal.

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

VOL. XXIII.—No. 12.] SEPTEMBER 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Fri., Sept.	1.	—Dr. Morley Fletcher and Mr. Bailey on duty.
Tues., ,,	5.	—Dr. Drysdale on duty.
Fri., ,,	8.	—Dr. Tooth and Mr. D'Arcy Power on duty.
Mon. ,,	11.	—Exam. for Matriculation (London) begins.
Tues., ,,	12.	—Dr. Garrod on duty.
Fri., ,,	15.	—Dr. Calvert and Mr. Waring on duty.
Tues., ,,	19.	—Dr. Morley Fletcher on duty.
Fri., ,,	22.	—Dr. Drysdale and Mr. McAdam Eccles on duty.
Mon., ,,	25.	—Exam. for Entrance Scholarships begins.
Tues., ,,	26.	—Dr. Tooth on duty.
Wed., ,,	27.	—First Exam. Conjoint Board begins.
Thurs., ,,	28.	—Second Exam. Conjoint Board begins.
Fri., ,,	29.	—Dr. Garrod and Mr. Bailey on duty.
Mon., Oct.	2.	—**Winter Session begins.** Cambridge Michaelmas Term begins. Exam. for Part II of Second M.B.(Camb.) begins. Exam. for D.P.H.(Camb.) begins. First Exam. Society of Apothecaries begins.
Tues., ,,	3.	—Dr. Calvert on duty. Final Exam. Conjoint Board (Medicine) begins.
Wed., ,,	4.	—Second Exam. Society of Apothecaries begins.
Thurs., ,,	5.	—Final Exam. Conjoint Board (Midwifery) begins.
Fri., ,,	6.	—Dr. Morley Fletcher and Mr. D'Arcy Power on duty. Final Exam. Conjoint Board (Surgery) begins.

EDITORIAL NOTES.

WE have again to record the passing of another year of war. And this period has not passed us by without leaving its mark heavily impressed upon us. Twice the number of Old Bart.'s men have given their lives for their country this year than in the first year of the war. The hospital staff has been further depleted, so much so that on the surgical side it is now necessary to extend the "duty periods" to the duration of a week—a time of extremely heavy work for both the visiting and resident staff on duty.

But, in spite of all, we have succeeded in rubbing along in an amazingly cheerful and normal manner considering the conditions and times. The clubs have kept themselves together, and when unable to get "fixtures" they have arranged practice games among themselves. The Abernethian Society has held several very successful meetings. The Students' Union still pursues its avocation, albeit with somewhat diminished funds. The JOURNAL still manages to hand a small profit over to the Students' Union.

Now we are entering upon a third year of strife and turmoil—may we still be able to carry on.

* * *

It had been the intention of the JOURNAL to publish a further supplementary list of those whose names are engraved upon the Roll of Honour, or who are serving in the forces in one capacity or another. Considerations of economy have, however, induced us to postpone the Supplement upon this occasion, but we hope to produce one in the Spring of next year, when we may also be able to publish further photographs of our companions who have fallen in the fight.

* * *

We note with great regret that Dr. Robert Armstrong-Jones, acting on medical advice, has tendered his resignation as Medical Superintendent of Claybury Asylum, a post which he has held for nearly twenty-four years.

Dr. Armstrong-Jones's record as a worker in the field of psychological medicine is a distinguished one. As the first Medical Superintendent of Claybury he laid the foundations upon which have been built a great part of our present system of treatment in asylums. As a clinical worker Dr. Armstrong-Jones was very successful, and his activities ran parallel to those of Dr. Mott, at Claybury, in the branch of pathology. Further, Claybury was the first asylum to establish the control of private patients under municipal direction.

The Asylums Committee of the L.C.C. have presented Dr. Armstrong-Jones with their resolution of regret as an

illuminated address, and the Home Secretary has just sanctioned a special pension to him recommended by this committee of the Council.

Dr. Armstrong-Jones is now one of the Consulting Physicians in Mental Diseases to the Military Forces in London, and also Lecturer on Mental Diseases to St. Bartholomew's Hospital.

* * *

The King has granted to Dr. Ll. C. P. Phillips, Professor at the Government School of Medicine, Cairo, and Physician to the Sultan of Egypt, his authority to wear the Insignia of the Third Class of the Order of the Nile.

* * *

It is with mingled pride and sorrow that we notice the name of Captain J. L. Green, R.A.M.C., V.C., among the fallen. Pride because one of our Old Bart.'s men should have gained the coveted Victoria Cross, sorrow because by the deed which gained it he has lost his life. Captain Green was educated at Felstead School, Downing College, Cambridge, and St. Bartholomew's Hospital. He took his M.R.C.S., L.R.C.P., in 1913, but had not quite completed his course for the Cambridge M.B. when on the outbreak of war he obtained a commission in the R.A.M.C. He was at first attached to the 5th South Staffordshire Regiment, then to a field ambulance in France, and lastly to the Sherwood Foresters, with whom he was serving when he met his death. During a recent action he was wounded, but though wounded he went to the assistance of an officer in similar plight who was hung up on the enemy's wire-entanglements. He succeeded in dragging this officer to a shell crater, where he dressed his wounds, notwithstanding that bombs and rifle grenades were thrown at him the whole time. Captain Green then endeavoured to bring the officer into safe cover, and had nearly succeeded in doing so when he was himself killed. Our most heartfelt sympathy is extended to Mr. and Mrs. J. G. Green in their sad bereavement.

* * *

With great sorrow we have to record the death of Captain A. J. Waugh, R.A.M.C., who was killed in a recent action in France. He was attached to the 1st North Staffordshire Regiment at the time of his death, and his commanding officer speaks very highly of his attainments and companionship. The following extract from a letter written by this officer to his father tells how he met his death on the battle-field: "We were being relieved, and our relief was very late. . . . I sent the adjutant with a message to the brigade, and your son and I stood waiting together as it was possible the adjutant might miss us in the darkness and confusion; I told your son to keep a look-out at one point while I did the same at another. . . . He moved perhaps ten yards from me. Hardly had he done this when a 4·2 shell fell almost at his feet, killing him instantly. We had several more shells close to us, and presently the adjutant and I went to look for your son and found him lying where he had been standing. He did not appear to have been struck, and must have been instantly killed by the explosion and shock. . . . We placed his body in a safe spot, and early next morning sent a limber up for it and removed it to Carnoy, some little distance from the front, and he was buried by the chaplain in the cemetery there. . . ." Our sincerest sympathy is extended to Mr. and Mrs. Waugh in their sad bereavement.

* * *

It is with the deepest regret that we learn of the death of Captain Douglas Henry David Wooderson, R.A.M.C., who was killed in action on August 6th. He was well known and well liked by his many friends at the Hospital, and at the time of his death was M.O. to the King's (Liverpool) Regiment. Our deepest sympathy is extended to Mr. and Mrs. H. D. Wooderson in their bereavement.

* * *

Another of our past students has died of wounds received during the recent advance. Captain Richard Molesworth Dennys, to whom we refer, was educated at Winchester School and took his M.R.C.S., L.R.C.P., at this Hospital. Early in the war he offered his services to the Red Cross Society and to the Royal Army Medical Corps, but was at that time informed that no more medical men were wanted, and in October, 1914, he accepted a combatant commission as temporary Lieutenant in the Loyal North Lancashires. In the following December he was promoted to be Captain. He was a very hard worker and thoroughly understood his men, and of him a brother officer writes that "the men worshipped him." Our deepest sympathy is extended to his parents, Mr. and Mrs. Edward A. Dennys, in their sad loss.

* * *

With much sorrow we learn of the death of a well-known Old Bart.'s student, Sir William Henry Power, K.C.B., F.R.S., F.R.C.S., who died on July 28th in his seventy-fifth year. He was educated at University College and at this hospital and took his M.R.C.S. in 1864. During his very active life he filled many public posts and carried out many investigations of exceptional utility. In 1908 he was created K.C.B. A fuller obituary notice appears on another page of this issue.

OUR RETROSPECT.

ONCE again, in reviewing the last year, our attention must be drawn to our Roll of Honour rather than to the usual work and progress of our Medical School. A year ago over fourteen hundred of our physicians, surgeons, students, past students, nurses,

and lay staff were serving with the Forces either at home or abroad. Since then this number has been augmented by a further four hundred, bringing our total up to over eighteen hundred. Unfortunately, during the twelve months many of these have been killed in action, or have died of wounds, or from causes directly attributable to active service; indeed, the number is twice as many as during last year, twenty-six old Bart.'s men having been killed since last August as against thirteen in the previous year. The number of wounded we do not know accurately, but it is considerable. The decorations which have been bestowed upon our more fortunate brothers on service will be mentioned in a later paragraph.

Several members of our staff have left England on active service.

Colonel A. E. Garrod left for the Mediterranean as Consulting Physician to the Expeditionary Forces.

Colonel Tooth went to Malta in the capacity of Consulting Physician to the Expeditionary Forces. Major Hamill has also left for Malta.

Major Gask joined the Expeditionary Force in France.

Major L. B. Rawling, Captain Stanley, and Lieutenant Mackenzie Wallis left England for India.

Mr. Harmer went to Russia to join the Anglo-Russian Hospital.

Turning our attention to the Medical School, we may congratulate ourselves on the work which it has been able to carry on. Of necessity the number of new students has fallen somewhat, and early in the year a large number of Junior Students joined the Forces, thus reducing our numbers. Nevertheless, full courses of lectures and laboratory classes have been held, and these have been well attended. As for the examinations themselves, the war seems to have acted as a stimulant, for the percentage number of successful candidates has been even higher than our previously good records.

The permanent staff of the Hospital has fortunately suffered no loss by death during the past year, but several of our past students, since famous in their different spheres, have to our grief passed to the Great Beyond.

Sir George Newman has retired from the Lectureship on Public Health, and the Governors have appointed him Emeritus Lecturer in recognition of his valuable services to the School. He has been succeeded by Dr. R. A. Lyster.

Mr. R. Gill has resigned the post of Chief Chloroformist to the Hospital.

We have to record with sorrow the death of Dr. W. G. Grace, the finest cricketer the world has ever known. Probably he was more widely known than any other Bart.'s man, although, of course, his fame was as a sportsman, and not as a physician. That he was one of the kindliest and best of men is well known, and many are those who can speak of the "good turns" which he has done for them.

We have also to record with sorrow the death of Dr. Herbert Williams, whose work as Medical Officer of Health for the Port of London was of vast importance to the country, although seen and understood by comparatively few. So many reforms did he institute or administer that his name became known throughout the world in all matters of port sanitary administration. In order to be able to deal personally with foreigners, he learnt to speak French, German, Spanish, and Yiddish. Stern and inflexible of purpose, yet was he kind, considerate and sympathetic; he could be written of as one who loved his fellow men. No student has ever been prouder or more mindful of the best interests of his Hospital than was Herbert Williams, and by his death London has lost a great and useful man.

We have also to note with sorrow the death of Sir William Turner, K.C.B., F.R.S. He joined the Hospital School in 1849 and took his M.B. in 1857. He was an excellent anatomist and secured the post of Demonstrator of Anatomy to John Goodsir, the Edinburgh professor. In 1873 he represented the University of Edinburgh on the General Medical Council, which maintained his services until he became its President in 1898. On Goodsir's death he became Professor of Anatomy, and later, on the death of Sir William Muir, he became his successor as Principal of the University. Lister was one of his firmest friends and they did a great deal of work together. In 1901 Turner was awarded the K.C.B., and Edinburgh conferred the freedom of the City upon him. St. Bartholomew's will always be proud to reckon him *olim alumnus*.

It is with much regret that we have also to record the death of Sir Francis Henry Lovell, Dean of the London School of Tropical Medicine, at the age of 71. He began his life work as Colonial Surgeon of Sierra Leone, 1873–1878. From Sierra Leone he went to become Chief Medical Officer of Mauritius and member of the Legislative Council, 1878–1893; later he was appointed Surgeon-General of Trinidad and Tobago and member of the Executive and Legislative Councils, 1893–1901. He retired from the Colonial Office in this latter year, and in 1903 was appointed Dean of the London School of Tropical Medicine. Sir Francis was created C.M.G. in 1893 and knighted in 1900. He was a Fellow of the Royal College of Surgeons.

Among the appointments which reflect credit upon our School we may mention the following: Colonel H. Hendley, I.M.S., has been appointed Honorary Surgeon to the King. Lieut.-Colonel F. E. Swinton, I.M.S., has been appointed Deputy Director-General of the Indian Medical Service. Dr. W. M. Willoughby has been appointed Medical Officer of Health for the Port of London, while Dr. J. S. Warrack has been appointed his Deputy.

Among other distinctions awarded to St. Bartholomew's men we may mention the following:

Dr. Calvert has been elected a member of the Council of the Royal College of Physicians of London.

Sir Francis Champneys has been elected representative of the same College on the Central Midwives Board.

Sir Dyce Duckworth has been elected a "Membre Correspondent étranger" of the Academy of Medicine in Paris.

Mr. D'Arcy Power has been elected a member of the Executive Committee of the Imperial Cancer Research Fund: he has also been elected President of the Medical Society of London.

Dr. Robert Armstrong-Jones has been elected a Vice-President of the Medico-Legal Society.

Dr. Arthur J. Hall has been appointed to the Professorship of Medicine at the University of Sheffield.

Sir C. P. Lukis, Director-General of the Indian Medical Service, has been appointed Commissioner for the St. John Ambulance Brigade Overseas, within the Empire of India.

Professor F. W. Andrewes has been appointed to the Senate of the University of London as representative of the Faculty of Medicine.

Among the Birthday, New Year, and Military Honours there are several well-known names.

Dr. Christopher Addison has been made a Privy Councillor.

Surgeon-General Sir Anthony Bowlby has been created K.C.V.O.

Mr. Milsom Rees has received the honour of knighthood.

The following have been appointed C.B.: Surgeon-General H. D. Rolleston, Surgeon-General W. G. A. Bedford, Colonel O. R. A. Julian, Lieut.-Colonel W. W. Giblin.

The following have been appointed C.M.G.: Colonel A. E. Garrod, Colonel C. E. Harrison, Lieut.-Colonel C. Gordon Watson, Lieut.-Colonel L. Humphry, Lieut.-Colonel R. Pickard, Major H. M. Cruddas, Major W. W. Jewdwine.

Major F. N. White has been appointed C.I.E.

Dr. J. B. Christopherson and Prof. L. C. P. Phillips have had the Order of the Nile (third class) conferred upon them by the Sultan of Egypt.

The coveted honour of the Victoria Cross has been awarded to Capt. J. L. Green, R.A.M.C., who, alas, was killed in performing the deed which gained it.

The following have been awarded the Military Cross: Capt. R. S. Townsend, Capt. D'Arcy Power, Capt. L. R. Shore, Capt. G. E. Dyas, Capt. T. J. C. Evans, Temp. Capt. A. J. Kendrew, Surg.-Capt. W. T. Rowe, Capt. C. J. Stocker, Lieut. C. C. Okell, Capt. D. C. G. Ballingall, Capt. T. M. Miller, Capt. E. B. Allnutt, Capt. R. C. Clifford.

The following have received the D.S.O.: Lieut.-Colonel E. P. Sewell, R.A.M.C., Major R. W. Knox, Major A. A. Maden, Major C. H. Turner, Major W. R. Battye, Surgeon B. A. Playne, R.N.

Major W. R. Battye has also had the Decoration of the Legion of Honour Croix de Chevalier bestowed on him by the President of the French Republic.

The Order of St. Sava, 5th class, has been conferred by the King of Serbia on Capt. L. A. Walker, Capt. G. Whittington, and Capt. J. S. Williamson.

During the year we have maintained a high reputation at the various examinations.

At the University of Cambridge four have obtained the M.D. One has obtained the M.C., six have taken the M.B., B.C., while several others have taken the examination for either the first or second part of the M.B. or B.C.

At the University of Oxford one has taken the M.B., B.Ch.

At the University of London one has taken the M.S. and three the M.B., B.S. (G. C. Linder obtaining honours and the University Medal).

At the University of Dublin one has obtained the M.B., B.Ch., B.A.O.

At the Royal College of Surgeons of England six have obtained the F.R.C.S.

At the Royal College of Physicians of London two have been elected Fellows and one has obtained the M.R.C.P.

Of the Conjoint-Board examinations two have obtained the D.P.H., and fifty-six have obtained the diplomas of M.R.C.S., L.R.C.P.

Three have taken the diploma of L.M.S.S.A.

The Scholarships and Prizes have been well contested, and the following is a list of the winners during the year 1915–16.

Luther Holden Scholarship.—F. W. Watkyn-Thomas.

Brackenbury Medical Scholarship.—H. G. E. Williams.

Brackenbury Surgical Scholarship.—A. R. Dingley, J. B. Hume (æq.).

Willett Medal.—K. A. I. Mackenzie.

Walsham Prize.—A. Morford.

Bentley Prize.—J. B. Hume.

Wix Prize.—A. Morford.

Sir George Burrows Prize.—A. Morford.

Skynner Prize.—H. M. Wharry.

Shuter Scholarship.—E. B. Verney.

Junior Scholarships: Biology, Chemistry, and Physics, 1915.—(1) Not awarded; (2) J. T. Long.

Junior Scholarships: Anatomy and Physiology.—(1) C. L. Hewer; (2) W. E. Lloyd, I. G. Williams (æq.).

Harvey Prize.—A. D. Wall.

Kirkes Scholarship and Gold Medal.—J. B. Hume, S. G. Dunn (*prox. acc.*).

Senior Scholarship in Anatomy, Physiology, and Chemistry.—A. D. Wall.

Junior Practical Anatomy (*Treasurer's Prize*).—(1) I. G. Williams; (2) W. E. Lloyd; (3) J. N. Leitch.

Senior Practical Anatomy (*Foster Prize*).—(1) A. D. Wall; (2) B. B. Sharp; (3) H. C. Cox; (4) M. Jackson; (5) H. N. Hornibrook.

Senior Entrance Scholarships in Science.—(1) L. P. L. Firman-Edwards, I. G. Williams.

Junior Entrance Scholarship in Science.—C. Shaw.

Entrance Scholarship in Arts.—J. V. Landau.

Jeaffreson Exhibition.—A. C. D. Telfer.

NOTES FROM A MILITARY HOSPITAL.

BY C. HAMILTON WHITEFORD, M.R.C.S., L.R.C.P.

Aneurysm of Right Superficial Temporal Artery.

FOUR months previously a bullet entered the skin over the base of the right mastoid process, passed through the ear and emerged on the face, one inch in front of the external meatus.

Present Condition.—The right superficial temporal artery is dilated for two inches to a diameter of a quarter of an inch, being three times as large as its fellow. The dilation commences at the upper border of the zygoma and extends upwards.

There is no paralysis of the upper branches of the facial nerve. Since the injury the hearing power of the right ear has greatly diminished, a watch being heard only at half an inch from the ear. The symptoms produced are slight. The patient complains of vague pains in many areas of the scalp, and is conscious of the pulsation whenever he takes active exercise.

If severe symptoms develop, or if the aneurysm increases, it is proposed to excise the dilated portion of the artery.

Gunshot Wound of Neck.—Paralysis of Deltoid Muscle.—Treated by Relaxation of the Paralysed Muscle, aided by Massage and Electricity.—Recovery without Operation.

On October 13th, 1915, a rifle bullet entered the back of the right shoulder and emerged in the right side of the neck.

The right arm at once became paralysed and anæsthetic throughout. Sensation began to return four hours after the injury, and was gradually followed by return of movement.

For the next six weeks he was in a hospital and was treated with massage and electricity, but the arm was allowed to hang by the side.

On admission to the military hospital, Devonport, he was found to have a small scar of entry one inch above the upper angle of the right scapula, and a wide scar of exit two inches in length situated in neck, two inches above the centre of the right clavicle.

The right deltoid muscle was paralysed and atrophied. The arm could not be voluntarily raised from the side.

The only area of anæsthesia was situated below the centre of the right clavicle, probably due to injury of cervical cutaneous nerves.

A skiagram failed to show any foreign body or bone lesion.

The right arm was supported on a platform splint made of poroplastic with wooden supports. This splint held the arm and forearm on a level with the shoulder and kept the deltoid muscle relaxed. Electricity and massage were continued.

After two months of the above treatment the condition was as follows: The right arm could be fully extended above the head to the same extent as the left arm; the deltoid muscle was increasing in volume and could be seen to contract voluntarily.

The above is one of a number of cases of paralysis following gunshot wounds in which the writer has seen recovery follow similar treatment.

If recently paralysed muscles are treated systematically by prolonged relaxation, assisted by massage and electricity, the necessity for operation frequently disappears.

Inexperienced operators are apt to jump to the conclusion that the presence of a scar in the neighbourhood of a nerve, if associated with either anæsthesia or paralysis, is an indication for immediate operation, and if improvement follows operation, ignore the fact that the operation has often been quite unnecessary, and that improvement has occurred, not because of, but *in spite of*, the operation. In the above case, if an operation had been performed, what an excellent result might have been claimed for the operation.

Gunshot Wound of Skull.—Death Six Months later from Multiple Cerebral Abscesses.

On September 26th, 1915, the patient was hit in the centre of the forehead by a cross-fire rifle bullet, which produced a horizontal gutter fracture, commencing half an inch to the right of the mid-line, two and a half inches above the root of the nose, and extending to the right for two and a half inches.

The result was unconsciousness for two days, during which an operation was performed.

He passed through several hospitals, and the wound did not heal till January, 1916.

When seen on March 25th, 1916, his condition was as follows: The headache, which had been present since his injury, had during the last seven weeks (*i.e.* since the healing of the wound) become intense. Pain commenced in the scar and spread round the right side of the head. There was no marked tenderness. The scar pulsated slightly. The gap in the right frontal bone could be plainly felt and measured 1 in. by 2½ in. There was no vomiting. There was slight weakness of the muscles at the left angle of the mouth. Cerebration was slow and speech was drawling. Incontinence of urine and fæces occasionally occurred. Temperature 98° F. Pulse 58. Respiration 20.

The skiagram shows four spicules of bone apparently embedded in the right upper frontal lobe, also a long fissured fracture, which extends from the gap in the frontal bone horizontally on the right side to the back of the skull. The leucocyte count was 9400.

The Ophthalmic Surgeon reported: "There is commencing optic neuritis, the amount of the swelling is small."

Operation.—On March 30th, 1916, a large semi-circular scalp flap, with the scar in the centre, was turned downwards, exposing the gap in the right frontal bone.

On incising the scar-tissue, which filled the gap in the bone, the underlying tissues were found to be œdematous. A finger, inserted into the softened brain, palpated, one inch beneath the cortex, fragments of bone which were firmly embedded and partly encapsuled.

Two drachms of pus escaped and five pieces of bone were removed with forceps.

The fragments of bone were flat, the largest piece measuring three-quarters by half an inch.

The abscess cavity was drained by a perforated metal tube $\frac{3}{4}$ in. in diameter and $1\frac{1}{2}$ in. in length.

The tube was brought out through the scar in the scalp flap, and was filled with glycerine.

A small drainage-tube was placed at each angle of the scalp flap. Irrigation, with saline solution, was freely employed. During operation the pulse-rate rose from 54 to 100.

Post-operative condition.—First and second days.—The metal tube was rotated and washed out daily, and was refilled with glycerine. The general condition at first improved, and then relapsed to the state prior to operation.

Fourth day.—Temperature, 98 ; pulse 56. Cerebration much slower. Under a general anæsthetic two lumbar punctures, made by a bacteriologist of large experience, failed to find fluid. The metal drainage-tube was taken out, cleaned, and replaced, a small amount of softened brain matter being removed with forceps.

Fifth day.—More drowsy.

Sixth day.—Coma and death.

Autopsy.—There was no meningitis and comparatively little softening in the right frontal lobes, in which there were a few minute spicules of bone.

The anterior portion of the right temporo-sphenoidal lobes was occupied by two thick-walled abscesses. The smaller abscess was 1 in. in diameter. The larger abscess contained 2 oz. of thick green pus and a piece of flat bone $\frac{1}{2}$ in. square. The rest of the brain was normal.

Comments.—Neither the abscess nor the contained bone appeared in the skiagrams.

The only localising symptom was the very slight facial paralysis round the left angle of the mouth.

Drainage of the frontal abscess by means of the perforated metal tube and glycerine appeared to be efficient.

Chronic Internal Derangement of Knee-joint.—Results of Operations.

The writer has had many opportunities of noting the end-results of operation, usually removal of the internal semilunar cartilage.

The primary lesion has often occurred at football.

It is the exception to find a knee which, after operation, does not, on commencing hard work, develop either pain, swelling, or lameness.

Reports from medical officers in charge of troops state that, after operation, these knees give out as soon as the patients route-march or jump into trenches.

Contrary to the opinion generally held, it is the writer's firm conviction that, in these chronically deranged knees, operation can only very rarely be expected to make the man fit for active service, and that the taking of such knees into a military hospital for operation means the useless blocking of badly-needed beds.

Disintegration of Testis following Tapping of Hydrocele, the Tunica Vaginalis being Posterior to the Testis.

Previous history.—During the past four weeks three attempts to tap the hydrocele had been made. Little, if any, fluid had been withdrawn, and the punctures had caused most acute pain.

On admission.—The left testis was three times as large as the right. The front of the scrotum was ecchymosed.

Operation.—The testis was exposed from the front. The subcutaneous tissues were greatly thickened. On deepening the incision the tunica albuginea was opened, and the testis was found converted into a diffluent stringy mass, which was wiped out with gauze. The epididymis was not seen, being probably buried in the thickened tissues. The tunica vaginalis was found behind the testis, much thickened and containing half an ounce of clear fluid. The tunica albuginea was closed by sutures, and the tunica vaginalis, brought forward from behind, was sutured over the front of the tunica albuginea. The scrotum was drained. Slight suppuration occurred.

Comment.—The above is a recognised abnormality. In a virgin case (*i. e.* where no attempts at aspiration have been made) transillumination is the best method of ascertaining that the testis lies in front of the tunica vaginalis. At the three attempted tappings the trocar probably entered the testis, which had undergone a necrosis which was almost, if not quite, aseptic.

No attempt had been made to inject the hydrocele with iodine or other liquid.

DREAMS AND THEIR INTERPRETATION.

(*An Address to the Abernethian Society.*)

By ROBERT ARMSTRONG-JONES, M.D., F.R.C.P.Lond., F.R.C.S.Eng.,

Lecturer on Mental Diseases, St. Bartholomew's Hospital, and Consulting Physician in Mental Diseases to the Military Forces in London; Resident Physician and Superintendent of the London County Asylum, Claybury.

(*Concluded from page* 126.)

The careful study of the mental life, normal and morbid, has been the work of modern science, which has elucidated and solved many of the dream combinations—together with other products of the imagination—by the acceptance of that intimate union which exists between mind and body.

Upon the close relationship between mind and body, it has been found that the chaotic play of images in dreams is able to throw much light upon normal mental processes and upon the laws which are observable in the working of the mind during the waking state; hence the appropriateness of studying dreams in this new light and the justification of a claim for those who study dreams to-day, truly to be called "interpreters," for they investigate, upon the solid and substantial ground of science, the intimate and fundamental activities of the human mind in health and disease, without the need of resorting to supernatural agencies which were evoked in former days.

The interpretation of dreams by the psycho-analytic method is based upon the theory that in the hidden mentalities or "unconsciousnesses" of our minds are found the explanation—perhaps the secret—at any rate the quite sufficient interpretation of many abnormal mental occurrences and divergent mental states, such as dreams, lapses of memory, absent-mindedness, obsessions, delusions, and all kinds of intrusions and dominations of semi-repressed thoughts, but it is extravagant to seek for these in any one instinct, as is claimed for sex.

It is hardly necessary to state that dreaming is not confined or limited to human beings. We are familiar with the appearance of dogs which jump and bark in their sleep, more especially after active excursions, or following upon hunting expeditions; those who keep canaries have doubtless heard their unexpected pipings whilst asleep.

In order to understand the nature of dreams it may be desirable to consider the physiology of sleep, and, although the exact cause of sleep is not definitely known, the concomitants of sleep are familiar. We know, for instance, that in sleep all the normal activities of the organism are appreciably lowered, and it is not certain that sleep itself is not a state of debility, for there is a lowering of the pulse-rate and of the blood-pressure; there is also a slowing down of respiration. There is probably, in addition, a state of venous engorgement, permitting the products of fatigue to pass by osmosis into the blood-stream or into the lymph channels during this engorgement, which is favoured by the supine position of the body when at rest, thus giving a fuller supply of blood to the head, and so predisposing the brain to dreaming; yet we do not know the inner state of the organ of mind, *i.e.* the intimate structure of the cells in the brain cortex during sleep, nor their relation and dependence upon the ductless glands, in particular the pituitary, as has been pointed out during hibernation. In regard to the nerve-cells, therefore, conjecture must take the place of certainty. The brain cortex, normally, is composed of innumerable cells and fibres, the latter forming the connecting links and threads between the cells, their function being to convey sense-impressions from without the body, and then to convey these transformed impressions outwards for the control and proper working of the various organs in the body.

In an average brain the cells or neurons are computed to number 9000 millions, so a thought, or an idea, or a purpose initiated in one cell, or a group of cells, is immediately linked up with thoughts from scores or hundreds of others by means of fine connecting fibres. It is believed (Lepine) that the fine fibres of the neuron—which are called dendrites from their tree-like appearance—undergo a retraction during sleep leading to a partial separation of their terminations, thus leaving a space, so to speak, which cuts off nerve currents and thus induces sleep. This being a theory only, it has naturally evoked another and an opposite explanation of sleep, viz. that sleep accompanies a greater and more extensive prolongation outwards of the fine nerve processes of the cells (Lugaro), which then touch each other more closely and intimately, thus diffusing rather than concentrating nerve energy, the effect of such a diffusion being to lower nerve-potential, and so to bring about a general loss of nerve energy, and thus to favour sleep. The whole nervous system thus presumably participates in the lowering activity of the circulatory and other systems during sleep, yet it is not ascertained whether this lowering is sufficient to interrupt the continuity of the unconscious as well as of the conscious life.

Dreaming, as is well known, can be induced by such agents as opium, alcohol, and tobacco, and this would favour the view that dreaming was a morbid process. It is certainly a process which more often occurs just before or just after the actual state of sleep, and for that reason these dreams are called "hypnagogic." It is general experience that there are more clear as well as more fantastic images just before going to sleep or just before being thoroughly awakened than occur during complete unconsciousness. It is doubtless also within the experience of everyone that the vivid scenes of the day are more clearly impressed upon the mind during the intermediate state between sleeping and waking than during sleep. Children often dream before going to sleep of events which occurred the previous day. The *Daisy Chain*, by Charlotte Yonge, caused dreams of carriage accidents, and *Peter Pan* caused dreams of flying to the "Never, Never Land" in the case of a clever, impressionable child.

The materials of which dreams are made are chiefly the *memories* of past experiences, although they are often modified by the influence of temperament and environment. Most dreams are buried in the unconcious mind, which is partly the reason that they can be so rarely remembered fully after waking; this is certainly the case with children. It is believed that the age of greatest dreaming, as well as that of the most vivid dreams, is between twenty and twenty-five years. Women sleep more lightly, and dream more than men do; it is certain, at any rate, that more women than men relate their dreams, and women who are accus-

tomed to dream sleep longer. The majority of dreams occur after 6 a.m., although many occur before four o'clock. The time during which a dream is enacted is wonderfully short; a few seconds of time in a dream would be equivalent to days in the waking state, and many dreams may be recorded in support of this statement. The precipitation of images in a dream is so great and the attention so lacking in precision that there is nothing to regulate them in time. An analysis of dreams points out that the great majority, 60 per cent. of them, relate to sight; thus the ancients were correct in describing them as "visions," whilst only 5 per cent. relate to the sense of hearing. Three per cent. have reference to taste, and only 1·5 per cent. to smell. In dreams the two senses, taste and smell, which are the oldest, most primitive, fixed, and organised of the senses, frequently attach themselves to sight and hearing, which nevertheless are easier disturbed because more highly evolutionised, the objects to which taste and smell relate being thus visualised or heard. The faculties of the mind, to borrow an abstraction, "go to sleep," as it were, in certain orders. We know that we feel fatigue so far as our "judgment" is concerned sooner than we do in regard to our sensory life; we hear sounds during a light sleep, and are sensitive to rays of light or to the sense of touch; but because the power of forming a judgment is affected early in sleep, there are imperfect associations and images, phantasies and pictures arise which are the common experience of all. Some power of association and some power of judgment are left in light sleep, but the lessened power of these two "faculties" in dreams reveals the unrestrained, incongruous, and disorderly pictures left on the mind.

It has often been pointed out that insanity and dreams are so closely allied that insanity has been described as a "waking dream," and a dream as a "sleeping insanity." The insane, like dreamers, are under the domination and control of illusions and hallucinations, but they adhere to their dreams or delusions, and no appeal to the senses, to reason, or to the judgment can reconstruct their mind; whilst dreamers, so long as they remain in the dream state, continue to experience their insanity, a reference to a fixed objective standard being impossible during sleep, so that the mind, for the time being, remains unsound. Here, however, the similitude ends, for upon an appeal to the senses and to reason the dreamer awakes, whereas the insane person continues in his unreason. It has been stated that dreams may be followed by insanity, and my experience confirms this, although it is doubtful if a dream can ever be the actual cause of insanity, both being probably the product of an already existing mental weakness. A lady under my care, C. W—, dreamt she had during the night cut her husband's throat and thrown his body out of the window. She grieved, worried, and became so distressed at her imagined murderous conduct towards her innocent partner that her mind became deranged, and she lapsed temporarily into acute insanity. A man, C. V—, used to dream that he had destroyed St. Bartholomew's Church, and was so alarmed at the notion he could be guilty of such sacrilege that he feared going to sleep, and he also became insane. Another man, H. E—, after the last air raid, dreamt that his room was being "bombed"; in his dream he saw the explosion, smelt the asphyxiating gas, heard the crackling of the fire, and from that moment his mind seemed to give way; but it is quite open to argument whether in each case the dream was not the first symptom of the mental breakdown caused by fear. It may not always be easy to separate hallucinations from dreams, but it is a fact that insane persons dream more often than do the sane, and the continued presence of hallucinations in them, together with the natural wish to explain hallucinations by some plausible, but erroneous factor, causes the insane mind to be one which is readily responsive to slight stimuli. It certainly explains why the insane are light sleepers and are more frequently disturbed by imagined causes than the sane. The rays of the moon penetrating between the folds of a curtain or along the margins of a window blind not only disturb sleep by the light they shed, but the rays may also suggest the figures of persons sent to watch them, or to endanger their lives—hence the wakefulness and dreams of the insane; and the general belief is true that these frequently experience exacerbations of their illness during a full moon. It is a fact, known to physicians, that many of our wounded soldiers home from the trenches suffer from dreams of a fearful and horrifying kind, due to the memory of constant explosions and of the awful effects of exploding shells upon human life. These dreams are accompanied with all the physical symptoms of fear; there is present a lowering of the surface temperature, there is also the blanched face, the anxious expression, and the perspiring skin.

Dreams are closely related to the condition described as somnambulism, which is one of intense abstraction and nearer to wakefulness than is the dream state. The sleep-walker is guided by the motive which actuated his waking moments, and he sometimes executes performances with a degree of perfection which is not even possible to one in perfect possession of his senses. I have known a nurse get up in the middle of the night, collect all the patients' day attire, and arrange the clothing for about forty patients at the foot of each bed, after which she proceeded to collect all plants and flowers from an adjoining bath-room and place them in the ward, as in the day-time. She then retired to rest, but upon awakening she had forgotten all the details of the sleep-walking incident.

The state described as "Abstraction," or "Reverie," is also related to the dream state. In this the attention is so fixed and concentrated upon a train of ideas that, although the eyes are open and sounds are heard, yet no impression

is made upon them by external objects. In the condition described as "Ecstasy," figures and landscapes may be seen as real; the former are most often seen by religious devotees and sojourners in the cloister. Blake, the artist, was able to concentrate his attention upon his dreams so as to remove all distraction. He could paint pictures without sitters, who were so real to his imagination that he could carry on conversations with them whilst painting their portraits. Among persons whom he thus painted were King Edward I and Queen Catherine of Arragon.

Another state of mental abstraction is the pleasant and extravagant kind called "Castle-building in Spain"; a condition in which imaginary scenes of an agreeable form are constructed and indulged in for the enjoyment or satisfaction anticipated. "Day-dreaming" is another state which is an entertainment that has probably been practised on occasion by each of my audience. "Trance," "lethargy," and "catalepsy"—when the mind is concentrated upon an absorbing but narrow range of ideas—are also related to dreams, and so are the "hypnotic" and other states of partial consciousness, but they cannot be entered into here.

We have referred to the "unconscious mind"; the phrase is so frequently met with that it is used in various senses. Carpenter used it in reference to certain psychical states which he described as "unconscious cerebration," during which acts were performed without the knowledge of the cognitive self; one forgets, for instance, a line of poetry, but remembers it later when one has ceased, consciously, to think of it. In the course of conversation one may forget a word, and having "waited and seen" the word recurs later without effort, perhaps, when the attention is engaged elsewhere. This tends to show that there are unconscious mental excitations going on of whose nature we are ignorant, but the thoughts are there in the unconscious mind all the same, and they seem to be interposed between conscious ideas, and to be dug up, as it were, with them. Possibly every conscious idea arises out of, and dies away into, an unconscious mental state, and according to some there are three degrees or kinds of thoughts. Firstly, thoughts of which we are conscious, and which, when given attention to, are raised into what is called the "focus" of consciousness; secondly, thoughts which are in the rest of the field of consciousness, which are present, but only in a state of inattention—for instance, in the theatre we are intent upon the evolution of dramatic situations, but are inattentive to the audience or oblivious to the staging; the third depth whence thoughts emerge is the unconscious area which could not attract attention until their position had been raised into the full and clear focus of attention by some association or suggestion.

It is preferable, I think, to limit the term "subconsciousness" to the second of these states, in which there is still present a certain limited sensitiveness left to ordinary sense-impression, whilst the "unconscious" state represents the third, *i. e.* the primitive mind, so to speak, out of which conscious thoughts and intellectual processes rise and grow. The motive force of our acts is believed by some to take its origin in the unconscious mind, whilst the directive and controlling force is in the upper conscious levels which thus regulate the lower.

The technical analysis of dreams assumes that there is a dynamic trend of "desire" in the unconscious mind which is ever seeking for the gratification of personal feelings, passions, and sentiments, as against the controlled thoughts of the conscious mind. Psychologists who urge this trend or tendency in the unconscious mind assert that it is kept back and restrained by some imagined power called the "endo-psychic censor," a purely fictitious and artificial ego which is continually struggling to repress the natural impulses and thoughts not acceptable to consciousness, this "censor" exercising a guardianship over sleep, even the deepest sleep. These psychologists describe the unconscious mind as an under-world of painful memories and wishes, always seeking to obtrude themselves, and always in health being more or less successfully kept under, "like steam in a kettle," by the artificial censor. When the passions emerge in the conflict they become the "latent" cause of dreams, obsessions, and longings; if dreams be the result, then the dream as remembered or recorded is the "manifest" dream, and the interpreter immediately attempts to elicit the latent wish of which the manifest dream is the symbol. By this analysis a clue is furnished to the real aim and personality of the dreamer.

Dreams are thus the resultant of a conflict between the censor and the repressed idea, the dream being the "compromise," and only to be solved by a code, for which an array of symbolism has been invented to serve as a key for its interpretation. If the dream be of the sea, for instance, then, according to the followers of Freud who have initiated this sex-meaning, it stands as a symbol for "life," as in their own words, "life needs the mightiest symbol, because existence depends upon the mighty and profound procreative force." If the dream be of an old house, then it is interpreted to be "the abode of life," and, to use the Freudian expression of the dream analyst, "we find it necessary to predicate a creative, myth-making tendency in the structure of the mind by means of which the currents of life beneath all thought become articulate."

This sexual theory is over-emphasised, and the Freudians who urge sex as the basic origin of all dreams, of all obsessions, and of all longings, impulses, and neuroses, are "sex-intoxicated," for in life's reality there are other primary and original instincts as well as sex, of which fear, anger, and hunger are the most common examples. All these run deep in the unconscious mind, and each has suffered far more repression than sex. It is against human experience that all dreams are desires, and it is repulsive that all dreams should be interpreted as relating to sex, and such an ex-

planation has brought these conclusions of what have been called "chimney-sweeping investigations" into deserved disrepute. In the analysis of dreams the method adopted for exploring the unconscious mind depends upon inferences drawn (i) from what has been described as free or spontaneous association, (ii) "word association," and (iii) reaction time. The latter has been much used in America as an auxiliary for the detection of crime by means of an instrument of extremely delicate mechanism, the examination revealing a shortened reaction period to word association if the accused be innocent, whilst the reaction period is longer if the accused be guilty, for he is endeavouring to keep back thoughts suggested to the mind in connection with the words presented to it.

What is the association of dreams with crime? I have questioned insane criminals about their dreams in connection with specific crimes, and although there is always some reserve about admitting revelations in connection with criminal acts, I find that they dream much as do other people. In this class there is a considerable difficulty in proving their hidden personal secrets, and in overcoming the resistance of the so-called "censor." In these cases the conscious and the unconscious cannot easily be brought together, and a clue as to their desires, impulses or wishes, is extremely difficult to ascertain. Moreover, this class is not an easy one to investigate; many of the criminal classes are mentally defective, although some are only morally so, especially as regards prudential considerations, for they cannot postpone present pleasure for future good. They are easily tempted and easily yield, and they have a diminished emotional as well as intellectual endowment. The "criminal type" is impulsive, and though these persons may not be insane they have often a psychopathic inheritance and tendencies. Their psycho-anthropological characters may be summarised as egotistic and anti-social, and they are not easy material for the psychological analyst. The discovery of crime through a dream, when the dreamer has by his own dream given himself away, is unknown to me in real life, and this is supported by the extensive experience of Dr. W. C. Sullivan. Dr. Leonard Guthrie reminds me of the story of the murder of Maria Martin by Corder in 1827, when dreams led to the discovery of the victim's body. As he also points out, there are numerous instances of murders having been discovered and avenged by the appearance of the murdered person's ghost. Shakespeare presents two instances in Hamlet and Macbeth. "The Bells," in which Irving represented the Jew Polonais, exemplifies a drama in which the murderer is being continually haunted by the dream-sound of the sleigh-bells, and in "Tom" Hood's *Dream of Eugene Aram* "the unknown facts of guilty acts are seen in dreams from God." The usher Eugene Aram dreamed of the murder he had committed, and which he related long afterwards to the boy—"the horrid thing pursues my soul, it stands before me now"; "that very night two stern-faced men set out from Lynn and Eugene Aram walked between with gyves upon his wrists." The suggestion here made connects the dream with the murderer's arrest. Hack Tuke relates a remarkable instance of a man dreaming that he had performed an act which rendered him liable to legal consequences, and for which he had been arrested. On awaking he was greatly relieved to find it was only a dream, but in the course of two or three days he committed the act in an insane condition of mind. He was arrested and brought before the court for trial, but was released to the care of his friends. There is no record of psycho-analysis asisting in or leading to the detection of crime, not even crimes relating to sex, for which the Freudians claim a peculiar affinity.

It will be admitted that a most puzzling terminology has arisen from the efforts made by medical psychologists to analyse dreams. If the dreamer fails to recognise the new and strange scenes in which the manifest dream is located, this is owing to its "dramatisation," but if the characters themselves are unrecognisable there is "distortion." Should the chief characters be given a subordinate position there is a "displacement," but not infrequently there occurs a fusion of the characters, which is "condensation." When the ideas or "complexes" in a dream become detached from their usual association and are "converted" into some other psychic sphere, then they are being "sublimated" into some obsession or delusion. Hysteria, for instance, is the "conversion" of a "repressed" idea into some motor and sensory discharge, and if only the idea can be disclosed to the sufferer and by him disregarded, the result is claimed as a cure obtained by a "cathartic," a word which is meant to signify suggestion, auto-hypnosis, or, as more recently hinted, "auto-gnosis."

I have quoted the above to show the complicated vocabulary invented by some psychologists to explain dreams which, as Bergson points out, are only states of "relaxed consciousness." In the waking state we are always adapting ourselves to our needs, but in sleep we have ceased to select and choose. The mind in its relaxed state brings together memory associations which were formerly packed away in the "storehouse of the unconscious mind," the reason fills up the gaps, and a confused impression results which is the material of dreams.

As is well known, the brain cortex is restored and refreshed only during sleep, and it is a comfort to know that we dream most about events to which no attention has been paid; were it not so, our sleep would be distracted and preoccupied by events that are of importance and which have been our concern during the day, so that our waking life would be prolonged as a permanent dream into the sleeping life and the necessary rest and nutrition of the brain would be impossible.

It is most welcome that the revival of interest in dreams

should have awakened the psychologist, physiologist and the philosopher, but progress must be at the expense of offending many susceptibilities and cherished proprieties. The decencies of sex have, I venture to think, suffered from this investigation, and I think there has been a pandering to the lower instincts in human nature through this revival, but I trust the matter has not been beyond the interests of the Abernethian Society.

OBITUARY.

SIR WILLIAM HENRY POWER, K.C.B., F.R.S., F.R.C.S.

IT is with feelings of deep regret that we announce the death of one of the most distinguished students of our Hospital, Sir William Henry Power, who died at East Molesey on July 28th, 1916.

His life's work was devoted to public health medicine, and as an epidemiologist he had no peer.

Born in London in 1842, he was educated at University College, and apprenticed at an early age to his father, a man well known as a successful medical coach. On entering St. Bartholomew's Hospital, Power was apprenticed to Fred Wood, the Hospital dispenser, who was a person of great importance in the medical wards, for there were no house physicians in those days. Power qualified in 1864 as M.R.C.S., L.S.A. He served as house surgeon for Mr. Holmes Coote, and then as resident medical officer first at the Royal Albert Hospital, Devonport, and then at the Victoria Hospital for Diseases of the Chest. Afterwards he did temporary work for the Medical Department of the Privy Council; and when, in 1871, the Local Government Board was constituted as the central office to deal with public health questions in England, Power was appointed a medical inspector of the new department. From 1887 to 1900 he was assistant medical officer, working successively with Sir G. Buchanan and Sir R. Thorne, and from 1900–1908 was principal medical officer of the Board. Some of Power's best-known work was done in the earlier period, in the local investigation of outbreaks of infectious diseases and their causation. He then showed, in a way hardly before realised, how much can be learnt about diseases and their prevention by painstaking inquiries into all the facts connected with epidemics, and by balancing all direct and circumstantial evidence with regard to them. He first demonstrated in this way in 1878 the spread of diphtheria by means of milk, and also the manner in which this disease is ordinarily carried, especially in schools, by unrecognised cases of slight sore throat—observations since fully confirmed by the advance of bacteriological knowledge. The relation between certain milk-borne outbreaks of scarlet fever and a diseased or "carrier" condition of the cow was brought out in reports made in 1885. An important series of investigations into smallpox between 1881 and 1886 proved conclusively that smallpox hospitals in London and elsewhere spread the disease characteristically among persons living in their neighbourhood, notwithstanding the administrative precautions taken. These reports led to the routine removal of smallpox cases to hospitals away from populous areas—a measure to which the diminution of smallpox in this country in recent years may be largely attributed.

When promoted to headquarters at Whitehall, Power continued his scientific and investigatory work under new conditions, acting as the trusted adviser and consultant of all the medical staff of the department, and of many other workers in the public health service. He closely guided and followed the work of the Board's medical experts, and gave it the stamp of his unrivalled knowledge, memory, and power of constructive criticism. The results are illustrated by the well-known series of annual medical reports issued by the Local Government Board during this period, and in the various special supplements, some of which, like those on shellfish and disease, lead-poisoning by water supplies, and the use and influence of tuberculosis sanatoria, have become classic. As a reference to these annual reports will show, Power's tenure of office covered a period when very considerable, if irregular, advances were being made in the application of medical science to central and local government, and in public health legislation, during which the lines of work of his own department became greatly extended.

Power's talents for administrative work were of a high order, and his sound judgment and knowledge of affairs were put unsparingly at the disposal of the Government Departments. He left himself no leisure for, and had little inclination to, public work outside his department. He was a Crown nominee to the General Medical Council, and succeeded Sir M. Foster as Chairman of the Royal Commission on Human and Animal Tuberculosis, the experimental work of which he largely directed. He gave similar services to the Royal Commission on Sewage Disposal, of which he was a member. He was created K.C.B. in 1908, and was the recipient of the Buchanan medal of the Royal Society and other honours.

STUDENTS' UNION.

A MEETING of the Council was held on August 22nd, Mr. Girling Ball being in the chair. Among other business done was the following:

The House Committee's report on the furniture in the Abernethian Room was read, and Mr. Perin's tender for repair of chairs was accepted.

It was agreed to allow the Special Constabulary to use the Hospital grounds at Winchmore Hill, and also to allow the use of the ground for the entertainment of soldiers.

An engraved portrait of Dr. Grace was submitted, but it was not thought to be sufficiently good for use as a memorial, and further search for a suitable portrait was decided upon.

Mr. Green's resignation from the Council was accepted with much regret, and a vote of thanks for his good services was unanimously adopted.

EXAMINATIONS.

UNIVERSITY OF LONDON.

First Examination for Medical Degrees, July, 1916.

T. Adam, C. H. Andrewes, K. H. Doouss, W. C. V. Higginson, J. V. Landau, C. W. Narbeth, H. L. Sackett, W. G. D. H. Urwick.

Second Examination for Medical Degrees, Part 1, *July*, 1916.

R. W. P. Hosford, A. E. Lorenzen, H. L. Sackett, Campbell Shaw, A. W. Taylor.

APPOINTMENT.

K. D. PRINGLE, M.B., B.C.Cantab., M.R.C.S., L.R.C.P., appointed Medical Officer to the Empire of India and Ceylon Tea Company, Borjuli, Assam.

NEW ADDRESSES.

L. A. ARNOULD, Bhusaval, Bombay Presidency, India.
F. BRICKWELL, 5, Hatfield Road, Ipswich.
T. H. F. CLARKSON, Lieut.-Col., R.A.M.C., 24, Festing Road Southsea.
C. H. FOWLER, Athol Cottage, Shottermill, Haslemere.
R. N. GEACH, 19, Hobart Place, Grosvenor Gardens, S.W.
P. J. LUSH, 48, Avenue Road, South Hampstead, N.W.
K. D. PRINGLE, Thakurbari, Darrang, Assam.
D. L. SPENCE, 80, New Cavendish Street, W.
H. E. WINTER, Lieut.-Col., R.A.M.C., Club of Western India, Poona.

BIRTHS.

FIDDIAN.—On August 12th, at Cambridge, to Capt. J. V. Fiddian, R.A.M.C., and Mrs. Fiddian—a daughter.

GRANDAGE.—On August 16th, at 74, Gloucester Road, S.W., the wife of Lt.-Col. W. B. Grandage, R.F.A. (T.F.), of a son.

GRAY.—On July 31st, at Yew Tree Cottage, West Malling, the wife of Henry Gray, M.R.C.S., of a daughter.

GRIFFITH.—On July 31st, at 2, Cavendish Road, St. John's Wood, N.W., to Helena and Harold Kinder Griffith, F.R.C.S. (Capt., R.A.M.C., T., 2/2 City of London Field Ambulance), a son.

JORDAN.—On August 17th, at 6, Maxted Park, Harrow, to Dr. and Mrs. Alfred C. Jordan (of 13, Upper Wimpole Street, W.), a daughter.

LEVY.—On July 31st, at 67, Wimpole Street, Cavendish Square, W., the wife of A. Harold Levy, F.R.C.S., of a daughter.

NICOLL.—On August 2nd, at Runfold, near Farnham, Surrey, the wife of Charles Vere Nicoll, Capt., R.A.M.C., Special Reserve, late of the Federated Malay States and Ceylon, a son.

ROSE.—On August 21st, at 68, Wimpole Street, W., to Mr. and Mrs. Frank A. Rose, a daughter.

SANKEY.—On August 23rd, at 35, St. Giles, Oxford, the wife of R. H. Sankey, Capt., R.A.M.C.(T.), of a son.

SEWELL.—On July 26th, at Coonoor, South India, of Dorothy, wife of Capt. R. B. Seymour Sewell, I.M.S., a daughter. (By cable.)

STANSFELD.—On Wednesday, August 16th, at 48, Bryanston Street, Portman Square, W., to Dr. and Mrs. A. E. Stansfeld, a son.

WALKER.—On June 22nd, to Dr. and Mrs. Norman H. Walker, of Davenport Road, Durban, Natal, a son.

MARRIAGES.

ALLNUTT—GAINSFORD.—On July 27th, at St. Saviour's Church Hitchin, by the Rev. G. B. Gainsford, Vicar, Edward Bruce Allnutt, Capt., R.A.M.C., to Joan Cicely, daughter of the Rev. G. B. and Mrs. Gainsford, of Woodside, Hitchin.

ATKINSON FAIRBANK—SALMON.—On August 1st, at St. Mary's Priory, Bodmin, by the Reverend Father McElroy, John Gerald Atkinson Fairbank, M.B., elder son of the late John Harrison Atkinson and Mrs. Atkinson, of 50, St. Charles Square, W., to Gladys Isatt, only daughter of Dr. and Mrs. O. G. Salmon, Bodmin, Cornwall.

CANE—PERKINS.—On July 24th, 1916, at St. John's, Meads, Eastbourne, by the Rev. John Salwey, Vicar, Maurice Hereward Cane, temp. Captain, R.A.M.C., youngest son of the late Leonard Cane, M.D., and Mrs. Cane, of Eastbourne, formerly of Peterborough, to Marjorie Amy, second daughter of H. J. Perkins, I.S.O., F.R.G.S., F.G.S., Surveyor-General, British Honduras, and Mrs. Perkins, of Wimbledon Park.

PRATT—WINCKLEY.—On August 8th, at the Parish Church, Houghton-on-the-Hill, Leicestershire, by the father of the bride, Capt. Oliver Beakley Pratt, R.A.M.C. (attached 8th Battalion Suffolk Regiment), son of Lieut.-Col. R. Pratt, R.A.M.C., T.F., and Mrs. Pratt, of Leicester, to Catharine Rose Thorold, eldest daughter of the Rev. S. Thorold Winckley, Rector of Houghton and Rural Dean, and Mrs. Winckley.

SAVORY—SUTHERLAND—On August 16th, at St. Mary-the-Virgin, Ringmer, by the Rt. Rev. the Bishop of Barking, assisted by the Rev. Preb. Poole, of Lewes, the Rev. Lawrence Gee, Rector of Hemel Hempstead, uncle of the bride, and the Rev. G. R. Leefe, Vicar of Ringmer, Charles H. Savory, Surgeon, R.N., eldest son of Arthur L. Savory, of 31, Bramham Gardens, S.W., to Aileen Mary, elder daughter of the late William Tudor Sutherland and Mrs. Sutherland, of Whitehall, Maidenhead.

DEATHS.

GRAY.—On August 15th, at 19, Beaumont Street, Oxford, Edward Benjamin Gray, M.D., in his 85th year.

GREEN.—Killed in action in France on July 1st, Capt. J. L. Green, V.C., M.R.C.S., L.R.C.P., R.A.M.C., attached 5th Sherwood Foresters, eldest and only surviving son of J. G. Green, J.P., of "Birchdene," Houghton, Huntingdon, aged 27.

LOBB.—On August 16th, 1916, at Kano, Nigeria, Hubert Peché Lobb (of "Endsleigh," New Milton, Hampshire), Provincial Medical Officer, Northern Nigeria, aged 40.

POWER.—On July 28th, at Holly Lodge, East Molesey, Sir William Henry Power, K.C.B., F.R.S., aged 73.

WAUGH.—Killed in action on August 18th, Captain Arthur John Waugh, R.A.M.C., attached to North Staffs Regt., third son of Mr. and Mrs. Walter Waugh, Chigwell Hall, Essex, aged 28 years.

WOODERSON.—Killed in action, on August 6th, Capt. Douglas Henry David Wooderson, M.B., R.A.M.C., Medical Officer in Charge of the King's (Liverpool) Regiment, dearly-loved elder son of Mr. and Mrs. H. D. Wooderson, 39, Dartmouth Road, Brondesbury, N.W., aged 24.

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