and a good nurse implies one who has been thoroughly trained.

The foundation of a "College of Nursing" is a step in the right direction, and the suggested introduction of "sister-tutors" cannot but tend for good.

CONCLUSION.

The possibilities of the future, and chiefly through sound, well thought-out reconstruction, are large, and it is for the Medical School and the Nursing School of St. Bartholomew's Hospital, whilst inheriting such splendid traditions from the past, to be prepared for greater and grander purposes in the future.

Our School mottoes point the way, for, while "Art is long and life is short," much can be accomplished if "Whatsoever thy hand findeth to do" is done with thy might. So be it!

RETURN.

I SUPPOSE that every man who returns from abroad, his war-labour ended, is greeted with the question, "Well, are you *glad* to get back?" The correct *riposte* to this conversational opening is a little difficult. The easy answer, "But of course I am," which for the first few days comes spontaneously and without reflection is true no doubt; but it has a double defect: it damps down effectually that approach to conversation, and it is certainly an economy of truth. For with few exceptions I imagine that most men, at least in our profession, feel a pleasure not unmixed with regret on their return. A friend of mine who himself has felt the difficulty has, I believe, diagnosed correctly the chief cause, when he observed that "We were devilish lucky, you and I, to have had this break in the routine of our lives." That, at any rate for the older among us, is an explanation in part of our inability to feel the unmixed delight which our friends seem to expect. We ought to be overjoyed at the termination of our exile, but even while we tell them that we are glad, we are rather shamed to know that we are not so glad as we would have them believe.

Here at home we live an ordered life, knowing that no day is likely to bring with it new untried experiences, or unusual event. Our work is planned days, weeks, or even months ahead; our pleasures are packed tightly into the crevices of the ordered plan; we shall rise, be surrounded from morning to evening with the arts and also the crafts of civilisation, and when our day is spent go to sleep with the knowledge that "to-morrow and to-morrow creeps in this petty pace from day to day." Whereas "out there"—France, Salonika, Mesopotamia, India, Africa, Asia, it does not matter where in the world—each day had possibilities of surprise, of joy, of pain, of delight, of discomfort, of the meeting of old friends, the forging of new ties, all in measure pressed down and running over; in fact, Routine, that tyrant of our lives at home, sank into insignificance. So that the honest answer to the question cannot be compressed into a brief acquiescence. We must go back to our school days, or even earlier, to our days of childhood, to find a parallel to these feelings, when life held all its surprises in store, and lavished them day by day—before custom lay upon us "with a weight heavy as frost."

So while we re-enter our ordered life with the pleasure with which we greet an old friend, yet we cast a lingering look to those days when every hour was "a bringer of new things," and we bend to the yoke of custom with a sigh for the past days, in which we old men renewed our youth, and the young men stored memories and experiences which will help them in their turn to bear without too much repining the burden of the years.

H. T.

REVIEWS.

THE INTENSIVE TREATMENT OF SYPHILIS AND LOCOMOTOR ATAXIA BY AACHEN METHODS. By REGINALD HAYES. Third Edition. (Baillière, Tindall & Cox.) Pp. viii + 92. Price 4*s.* 6*d.* net.

Now that it is no longer possible—and certainly not desirable even if it were possible—to send patients to Aachen, a detailed account of the methods employed in the treatment of syphilis will be welcome. The author gives a very clear account of the combined treatment of sulphur water internally and the daily inunction of mercury. Such treatment can quite well be carried out in this country, and providing the rubbing is systematically done the results are certainly very striking, especially in cases of syphilis of the central nervous system.

Reference is made to the use of salvarsan, and emphasis laid on the necessity of using mercury for a long period of time as an adjunct.

The four illustrations depicting the correct position of the patient during inunction add considerably to the value of the book.

ESSENTIALS OF MEDICAL ELECTRICITY. By ELKIN P. CUMBERBATCH. Fourth Edition. (Henry Kimpton.) Pp. 368. Price 7*s.* 6*d.* net.

The present edition has been thoroughly revised and many parts have been rewritten. The chapter on "Medical Ionisation" has been extended so as to include those diseases of women for which treatment by the ionic method is especially indicated.

An extremely interesting chapter is devoted to "Diathermy"; its uses in both medicine and surgery are dealt with in a most able manner.

Much new matter has been incorporated in the chapter on the "Electrical Testing of Muscle and Nerve," which also includes a note on the physiological and pathological principles underlying the subject.

There are several other additions as well as a number of new illustrations.

The book is very readable, and eminently suited to the needs of both student and practitioner.

ELEMENTS OF SURGICAL DIAGNOSIS. By Sir ALFRED PEARCE GOULD and ERIC PEARCE GOULD. Fifth Edition. (Cassell & Co.) Pp. 722. Price 12*s.* 6*d.* net.

In order to keep this work to a size which will conveniently slip into the pocket, and at the same time include much new data, the authors have considerably reduced the introductory matter. This we regard as unfortunate; it is a section of the book which should have been added to rather than curtailed.

Several new radiographic reproductions have been included in this edition, the majority of which are excellent. New matter on such subjects as "Gas Gangrene" and "Causalgia."

While the student will find in this volume much that is of value, we cannot confidently recommend the book for routine work. Diagnosis is most important, treatment equally so, and the object of the student should be to combine the two. It is on these grounds that we justify our statement regarding its value as a text-book.

CORRESPONDENCE.

A STATE MEDICAL SERVICE.

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

SIR,—As an example of what we may all be reduced to one day under a State Medical Service, I send the following extracts from a printed petition sent by the Sub-Assistant Surgeons to the Inspector-General of Civil Hospitals, Burma.

"The Humble Memorial of ———, Sub-Assistant Surgeon,

"Most Respectfully Sheweth:

"That the promise of a favourable consideration that was given to the Memorial submitted by the Members of the Sub-Assistant Surgeons' class in the year 1914, having not been even in the distant vision of fulfilment after a lapse of four years, your Memorialist submitted a reminder in the early part of 1918, the pressing need of which action was then plainly detailed.

. . . . . .

"That the reasons adduced for the increment so late as 1914 stand now vivified with unquestionable assertion.

". . . That when all the Provinces have generously bestowed the boon of increment spontaneously in the midst of war, and all the increases being a perceptible long jump quite unthought of and unexpected, your Memorialist feels depressed and dejected to find that the Province which was always the first to set examples to others in the granting of boons and in the redress of grievances, has become the last to hear the prayers of your Memorialist's class, keeping the Memorial pending indefinitely for five years.

"That the meagre pay now granted to your Memorialist's class acts detrimental to making the Rangoon Government Medical School popular, with the result that very few are attracted to fall into the miserable lot of your Memorialist.

". . . The necessity of revising the old order of things to make the future of the students bright and prospective traces itself in bold relief.

"That while emphasising the fact that the struggle to maintain his life is getting keener and harder, and that his case has to be looked into early, your Memorialist begs the grant of a scale of pay ranging from Rs. 150 to Rs. 350 per mendem, ... which will meet the pressing needs of your Memorialist, and go to make his life worthy of existence in the Medical world.

"For which act of kindness your Memorialist shall ever pray.

"——— L. M. P.,

"Your Humble Memorialist,

"*Sub-Assistant-Surgeon.*"

Under a State Medical Service at home will life be "worthy of existence in the Medical world?"

Yours faithfully,

L. B. CANE,

Capt. R.A.M.C.

O.C. INDIAN STATION HOSPITAL;

MEIKTILA, BURMA.

February 11th, 1919.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The degree of M.D. has been conferred upon G. A. Smythe.

UNIVERSITY OF LONDON.

First Examination for Medical Degrees. March, 1919: *Pass List.*

Trevor Davies, J. W. Poole, P. Thwaites.

Second Examination for Medical Degrees. March, 1919: *Pass List.*

Part I: Organic and Applied Chemistry.—R. S. Anderson, R. T. Bannister, G. L. Brocklehurst, C. O. S. B. Brooke, E. A. Coldrey, S. C. Cruden, M. Erfan, P. C. C. Garnham, C. F. Harris, J. P. Hosford, C. M. Jennings, R. Keene, J. H. R. Laptain, A. C. Maconie, G. S. Morgan, D. A. Robertson, B. M. Tracey, A. H. C. Visick, R. H. Wade, A. Walk.*

* Awarded a mark of distinction.

Part II: Anatomy, Physiology and Pharmacology.—F. C. W. Capps, K. H. Doouss, L. M. Jennings, W. E. Lloyd, D. M. Lloyd-Jones, G. J. V. Nelken, F. P. Schofield, G. J. Sophianopoulas, E. W. C. Thomas, R. A. Walsh.

APPOINTMENTS.

CUMBERLIDGE, W. I., M.B.(Cantab.), F.R.C.S., Capt. R.A.M.C., appointed Honorary Surgeon to the Leicester Royal Infirmary.

NUTTALL, W. W., M.D.(Durh.), appointed Certifying Surgeon under the Factory and Workshop Acts for the Folkestone District.

CHANGES OF ADDRESS.

BARRIS, J. D., *has returned to* 50, Welbeck Street, W. 1. (Tel. Mayfair 1751.)

BURROWS, Col. H., A.M.S., Consulting Surgeon to the Army of Occupation, c/o D.M.S., Cologne.

COUCHMAN, H. J., 4, Downing Street, Farnham, Surrey.

DOWNER, R. L. E., 32*a*, St. Aubyn's, Hove, Sussex.

EVANS, GEOFFREY, 37, Queen Anne Steet, W. 1. (Tel. Mayfair 5011.)

FRY, A. P., Knightwick, Worcester.

HOLTHUSEN, A. W., 583, London Road, Westcliff-on-Sea.

HOWELL, B. WHITCHURCH, 35, Weymouth Street, W. 1.

HUMPHREY, A. M., Horham Hall, Thaxted, Essex.

LUCAS, ALBERT, 141, Great Charles St. (Newhall Street), Birmingham.

MATTHEWS, Lieut.-Col. E. A. C., D.S.O., V.H.S., I.M.S., No. 5, Indian General Hospital, Port Tewfik, Suez, E.E.F.

SMYTHE, G. A., Buckingham House, Winchester.

BIRTHS.

PHILLIPS.—On March 28th, at Newstead, Waterloo Park, Liverpool, the wife of Lionel L. Phillips (late Capt. R.A.M.C.), grandson of the late Lewis Phillips, of Winchmore Hill, and son of the late Walter J. Phillips, J.P., of Totnes, Devon, of a son (Lewis).

SEWELL.—On March 20th, at Coonoor, India, Dorothy, the wife of Capt. R. B. Seymour Sewell, I.M.S., of a daughter.

DEATHS.

BRIGSTOCKE.—On February 12th, 1919, at a nursing home, Richard Wish Brigstocke, of the Old Rectory, Scole, Norfolk, and formerly of Beyrout, Syria, beloved husband of Elizabeth Brigstocke for fifty-three years, aged 80.

BUTCHER.—On January 10th, 1919, at Holyrood, Cleveland Rd., Ealing, W., W. Deane Butcher, M.R.C.S., aged 71.

GRIFFIN.—On April 1st, 1919, at Mundesley, Norfolk, John Purser Griffin, M.R.C.S., L.R.C.P., late of Baldock, Herts., third son of the late James Griffin, Esq., J.P., and Mrs. Griffin, of Southsea.

LEFTWICH.—On March 25th, 1919, Ralph Winnington Leftwich, M.D., C.M.(Aberd.) of 36, Ebury St., Eaton Square, London, aged 70.

MANTON.—On February 4th, 1919, at Shrewsbury House, Park, Sheffield, from pneumonia following influenza, John Albert Manton, M.R.C.S., L.R.C.P.

NESHAM.—On February 5th, 1919, at Ellison Place, Newcastle-upon-Tyne, Robert Anderson Nesham, M.R.C.S., L.R.C.P.

STOCKER.—On March 27th, 1918, reported "missing," now presumed killed, flying near Dompierre, Flight Sub-Lieut. Edward Cuthbert Stocker, R.N., younger son and only surviving child of Major E. G. Stocker, R.A.M.C.T., and Mrs. Stocker, Carn Brea, Cornwall, aged 18½.

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.*

St. Bartholomew's Hospital Journal.

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

VOL. XXVI.—No. 9.] JUNE 1ST, 1919. [PRICE SIXPENCE.

CALENDAR.

Fri.,	May	30.—Dr. Calvert and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues.,	June	3.—Dr. Fletcher and Mr. R. C. Bailey on duty.
Wed.,	,,	4.—Clinical Lecture (Surgery), Mr. Waring.
Fri.,	,,	6.—Sir Wilmot Herringham and Sir Anthony Bowlby on duty. Clinical Lecture (Medicine), Sir A. E. Garrod.
Tues.,	,,	10.—Dr. Tooth and Mr. D'Arcy Power on duty.
Wed.,	,,	11.—Clinical Lecture (Surgery), Sir Anthony Bowlby.
Fri.,	,,	13.—Sir A. Garrod and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Tooth.
Tues.,	,,	17.—Dr. Calvert and Mr. McAdam Eccles on duty.
Wed.,	,,	18.—Clinical Lecture (Surgery), Mr. Girling Ball.
Fri.,	,,	20.—Dr. Fletcher and Mr. Bailey on duty. Clinical Lecture (Medicine), Dr. Fletcher.
Tues.,	,,	24.—Sir Wilmot Herringham and Sir Anthony Bowlby on duty.
Wed.,	,,	25.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri.,	,,	27.—Dr. Tooth and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Sir Wilmot Herringham.
Tues.,	July	1.—Sir A. Garrod and Mr. H. J. Waring on duty.
Wed.,	,,	2.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri.,	,,	4.—Dr. Calvert and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Fletcher.

EDITORIAL NOTES.

WITH the very deepest regret we have to record the death of Mr. Arthur Watkins, for twenty-four years Steward to the Hospital.

No officer of the Hospital ever had its welfare more at heart, and if ever a man died in harness it was he.

The amount of work he got through was tremendous. There is no doubt that the strain, especially during the period of the war, hastened his death. By night and day he was ever ready to attend to convoys, and the well-being of our wounded soldiers was always his first consideration. It is no exaggeration to say that the Steward was loved by all, and his memory will linger for many years to come.

By a happy chance we are able to publish a photograph which in a way is historic, showing as it does the Steward seeing the last of the soldiers off from the Hospital.

Mr. Wilfred Watkins, Curator of the Surgery, and his sisters ask us to thank the numerous friends, particularly members of the Staff, who have written expressing their kind sympathy, as they find it quite impossible to acknowledge all the letters individually.

* * *

The Hospital was again favoured with the most perfect weather on the occasion of the Annual View-Day, which was held on May 14th. The attendance was hardly as large as we have seen, but the renewal of so many acquaintances, the revival of the dainty teas in the Wards, and possibly the fact that no longer was the Hospital subject to visits by enemy aircraft, made the afternoon a particularly happy one.

We are publishing elsewhere in this issue a description of the preparations which the Nursing Staff make on these occasions. The time-honoured inspection of the Wards by the Hospital officials also affords copy for our modern Shakespearean contributor.

* * *

It is most pleasing to see the Hospital getting back to pre-war conditions, especially as far as the social side is concerned. The Cricket Club is well under way, and two elevens are playing regularly every week. The Rifle, Swimming, Boxing and Tennis Clubs all show promise of having a successful season. We are very delighted to learn that the Musical Society is again in evidence. Under the energetic secretaryship of Mr. Hilton practices have already begun. This is one of the few—we almost said very few—social functions where the Nursing Staff can co-operate, and we look forward to a really first-rate concert in the not distant future.

* * *

The first Annual Dance since 1914 was held at Prince's Galleries on Friday, May 23rd.

The complete success of the evening was largely due to Mr. E. F. Peck and the two committees, who have worked very hard, and are to be congratulated on the result of their efforts.

The company numbered just over 300, and it is expected that a substantial surplus will be available for the New Nurses' Home. The success of the evening was greatly added to by Mr. Joyce's band, which was ever ready to give encores, and naturally the vivacious music contributed very largely to the pleasure of the dancing.

In the earlier part of the evening Mrs. H. J. Waring, President of the Ladies' Committee, was presented with a bouquet of roses.

* * *

We are asked to state that the Annual Past and Present Cricket and Tennis Matches will be held at Winchmore Hill on Wednesday, June 11th. The Artists Rifles' Band will be in attendance, and tea will be provided. A large gathering of Past and Present Bart.'s men is expected.

* * *

Our congratulations to the following St. Bartholomew's men on their election to the Fellowship of the Royal College of Physicians of London: Dr. G. A. Auden, Dr. A. E. Gow, Dr. P. Hamill, Dr. F. P. Mackie, and Dr. A. E. Naish.

* * *

It gives us much pleasure to congratulate Temp. Capt. (Act.-Major) A. Richmond, M.C., on being awarded a Bar to this decoration, and Lieut. E. R. Batho on receiving the Military Cross.

* * *

We are pleased to see that Lieut.-Col. T. H. Foulkes, I.M.S., has been brought to the notice of the authorities for gallant and distinguished services in connection with operations at Aden.

* * *

Our warmest congratulations to Mr. J. A. C. Forsyth, F.R.C.S., on receiving the Jacksonian Prize for the year 1918 for his dissertation on "Injuries and Diseases of the Pancreas and their Surgical Treatment."

* * *

The Treasurer's report for the year 1918 is just to hand, and contains several interesting items in connection with the Hospital.

It is with very great pleasure that we learn that H.R.H. the Prince of Wales has consented to become President of the Hospital. This office was vacated by His Majesty King George V when he became Patron of the Hospital on his accession to the Throne.

Another most gratifying item of news is that Her Majesty Queen Mary has graciously intimated her willingness to allow her name to be used in connection with the new Nurses' Home which is shortly to be built, and which will be known as "Queen Mary's Home (or Hostel) for St. Bartholomew's Nurses."

One of the first steps in Reconstruction, to which we gave such prominence in our last issue, is the establishment of an Out-patient Department in Psychological Medicine. The Department, which is under the direction of Sir Robert Armstrong-Jones, M.D., was opened on May 1st, and will be conducted on lines similar to those in other special departments.

* * *

We desire to remind old Bart.'s men of the memorial funds on behalf of the dependents of the late Mr. Harry Blakeway. Though suffering an initial disadvantage owing to the previous appeal of a very similar and sad need, the Fund, we are pleased to learn, is making good progress; Capt. A. Macphail, Anatomy Rooms, Treasurer, will gladly receive further donations.

* * *

The Committee of the Stansfeld Fund hope that anyone still intending to subscribe will do so before June 30th, on which date it has been decided to close the list.

Subscriptions may be sent to the Treasurer, Prof. F. W. Andrewes, the Pathological Department.

* * *

We understand that a Committee has been formed for the purpose of considering the question of a memorial to the officers and men of all branches of the R.A.M.C. who have fallen in the war. St. Bartholomew's is to be represented on this Committee by Sir Norman Moore, Bt., P.R.C.P., Major-General Sir Anthony Bowlby, K.C.M.G., K.C.V.O., C.B., A.M.S., and Maj. E. B. Waggett, D.S.O., R.A.M.C.T.

* * *

The following gentlemen were nominated to the Resident Staff commencing May 1st, 1919:

House-Physicians—

Sir Wilmot Herringham.	J. B. Hume.
	G. F. P. Gibbons.
Dr. Tooth.	A. G. Williams.
	C. E. Kindersley.
Sir A. E. Garrod.	H. W. C. Vines.
	H. A. Douglas.
Dr. Calvert.	F. T. Burkitt.
	F. G. Lescher.
Dr. Fletcher.	H. D. Kelf.
	M. V. Boucaud.

House-Surgeons—

Sir Anthony Bowlby.	R. G. Morgan.
	W. S. Sykes.
Mr. D'Arcy Power.	C. F. Beyers.
	P. Kittel.
Mr. Waring.	M. Barbash.
	C. W. Bennett.
Mr. McAdam Eccles.	C. F. Krige.
	G. A. Fisher.
Mr. Bailey.	E. M. Atkinson.
	R. M. Dannatt.

These appointments are made for a period of three months. Juniors will automatically become Seniors.

Intern Midwifery Assistant . . W. B. Heywood-Waddington.
House-Surgeon to Ophthalmic Department . . . . . J. E. A. Boucaud.
House-Surgeon to Throat, Nose and Ear Department . . . . E. B. Barnes.
House-Surgeon to Venereal and Skin Departments . . . . . C. H. Thomas.
These appointments are for six months.
Extern Midwifery Assistant . . . N. B. Thomas.
This appointment is for three months.

* * *

It is with sincere regret that we have received the news of the resignation of Mr. R. Cozens Bailey from the Surgical Staff of the Hospital. We are glad to hear, however, that although he will no longer be amongst us at the Hospital, Bart.'s men outside will still be able to have the advantage of his help in private practice—an asset which would be a great loss if he had decided to deprive us of this also while still in the prime of his surgical career. We wish him a long life and congratulations on his recovery from his illness.

* * *

Our readers will regret to learn of the death of Dr. A. G. Bateman, who for so many years was connected with the Medical Defence Union. It is largely owing to his enthusiasm and capacity for work that the Union has been brought to its present state of usefulness and value, not only to the members themselves, but also to the medical profession at large.

Just prior to his death Dr. Bateman had been made Chevalier of the Order of Leopold.

* * *

ROLL OF HONOUR.

We regret to have to report the death of three more Hospital men while on active service. To their relatives and friends we offer our sincere sympathy.

Temp. Capt. James Connor Maxwell Bailey, O.B.E., R.A.M.C., died in German East Africa on April 13th, aged 40. He was the only son of Mr. L. F. Bailey, of Dulwich, and was educated at this Hospital, taking the M.R.C.S. and L.R.C.P., and also the M.B.(Lond.) in 1901 and the M.D. in 1909. After serving as house-surgeon, gynæcological house-surgeon and senior house-physician at the West London Hospital, he joined the West African Medical Staff and served in South Nigeria. He took a temporary commission as lieutenant in the R.A.M.C. on March 1st, 1916, and was promoted to captain after a year's service. At the time of his death he held the post of principal medical officer in German East Africa. He received the O.B.E. on January 1st, 1919.

Major M. N. Perrin, who died as the result of an accident while flying, qualified in 1913. He held a commission in the R.A.F. Medical Service. Major Perrin, who was to have been demobilised the following week, was the only son of Mr. and Mrs. Perrin, of Kensington and Bushey Heath.

Temp. Capt. A. C. Sturdy, M.C., R.A.M.C., was educated at Cambridge and St. Bartholomew's Hospital, and qualified in 1909. He held appointments at St. Bartholomew's and at the Royal Free Hospitals, London; and prior to joining up was in practice at Horsham, Sussex, where he was public vaccinator to the urban district, and surgeon to the Cottage Hospital. He died at Bombay of dysentery.

MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

(*Continued from p.* 62.)

PNEUMONIA.

(85) The most certain differential sign in the diagnosis of pleuritic effusion from pneumonic consolidation of the lung is displacement of the heart. The next most important differential sign is abolition of the vocal thrill. But if the amount of fluid in the pleural sac be not large, or if the heart be fixed by adhesions, there may be no certain displacement of the apex-beat; and if pneumonia be accompanied by a small effusion into the pleura, the vocal vibrations may be absent. Whence it follows that cases are not infrequently met with in which the only method of differential diagnosis is an exploratory puncture of the chest.

(86) If consolidation of the lung be taken as the criterion of pneumonia, then the earliest physical sign of pneumonia to appear is impairment of the percussion note. And the last physical sign to disappear with resolution of the pneumonia is also impairment of the percussion note: indeed this sign may never completely disappear.

(87) A large experience of the post-mortem room shows that pneumonic consolidation confined to the middle lobe of the lung is not only much less common than is often thought, but that it is quite rare. Indeed, if we exclude collapse, to which the middle lobe is very prone, this portion of the lung is frequently found to be unaffected by the lesions that affect the lower and upper lobes.

(88) Apical pneumonia may be easily overlooked if the observer omits to examine the chest carefully in the regions of the supraspinous and infraspinous fossæ.

(89) Apical pneumonia is more common in children than in adults; the prognosis is usually better, and resolution is usually earlier, than in basal pneumonia.

(90) The term "broncho-pneumonia" is often used incorrectly to describe cases of pneumonia of lobar type in which the areas of consolidation are small and multiple. The term should not be used without due regard to patho-

genesis and to the course of the disease-process. Broncho-pneumonia may exist with a single area of consolidation, and lobar pneumonia may exist with several.

(91) Lobar pneumonia not infrequently recrudesces, but rarely relapses; broncho-pneumonia often does both.

(92) The four most serious complications of pneumonia are endocarditis, meningitis, pericarditis and peritonitis. Pneumococcal endocarditis is probably always fatal, because it is of the ulcerating variety. Pneumococcal meningitis and pericarditis are highly purulent, and are not much less grave in regard to their issue. Pneumococcal peritonitis is a less hopeless complication, probably because it is more amenable to surgical treatment.

(93) If rusty sputa are present in pneumonia, the examination of stained films gives fairly accurate information as to the nature of the lung infection. If no rusty sputa are available the only reliable guide to the nature of the infection is by lung puncture. Information derived from examination of mucoid or muco-purulent sputa may only relate to infection of the bronchial tract.

(94) Elderly patients not seldom emerge successfully from a severe lobar pneumonia to die of a bronchitis which complicates or follows it.

(95) Any event which lowers very considerably the general state of the patient during the course of pneumonia may delay resolution; nor must resolution be expected in any patient, quite apart from complications, if the general condition is very serious, nor so long as it remains so. For resolution is not a mechanical, but a vital, process, requiring a definite measure of activity on the part of the tissues concerned in order that it shall take place.

(96) Treat patients suffering from pulmonary tuberculosis with abundance of fresh air whenever practicable; treat patients suffering from pneumonia with abundance of fresh air whether practicable or not.

(97) In the treatment of pneumonia no amount of oxygen inhalation is likely to balance the deleterious effect of shut windows, a gas fire, a crowded room and the patient's bed in a *cul-de-sac*.

(98) Venesection in the cyanosis of pneumonia: the argument from theory, for and against, is immaterial, because in practice the procedure does not help.

(99) Troublesome cough during the early stage of pneumonia is either due to the acutely congested state of the upper respiratory tract or to associated pleurisy. In either case it is purposeless, and in the latter case it is also very painful; it is therefore a mistake to aggravate it by the use of stimulating expectorants such as carbonate of ammonium.

(100) Pending the results of certain promising efforts at specific therapy which are still on trial, the treatment of the pneumonic patient is "upon expectant lines." This term is regarded by some as an indication of the helplessness of the practitioner in face of this disease. But expectant treatment does not mean a policy of "wait and see." It means the careful oversight of, and an endeavour to assist to the utmost, the various functions by means of which the immune process takes effect. It is the duty of the doctor to provide for a liberal supply of oxygen to the lungs, and therefore to the tissues generally; to facilitate digestion and assimilation; to provide for rapid elimination by the lungs, bowels, kidneys and skin; to control the temperature; to maintain the tone of the heart; to rest the nervous system; to give confidence to the mind. Prompt and persistent attention to these things, or the neglect of them, not seldom makes the difference between life and death—a sufficient justification of the wisdom of not omitting thorough non-specific measures concurrently with any method of immunisation that may be embarked upon.

CERTAIN ASPECTS OF DIABETES.

By W. LANGDON BROWN, M.D., F.R.C.P.

[*Reprinted from "The Medical World," by kind permission of the Editor.*]

THE glands which control carbohydrate metabolism fall into two antagonistic groups; the first consists of the pancreas, whose internal secretion promotes the utilisation of sugar by the tissues and increases carbohydrate tolerance; the second comprises the thyroid, the pituitary and the suprarenal, the secretion of each of which mobilises the sugar into the blood and diminishes carbohydrate tolerance. The members of the second group have two other features in common besides this effect on carbohydrate metabolism; they are all associated with the activity of the reproductive organs, and they all have their secretion controlled by the sympathetic. It is the correlation between this group and the reproductive glands that accounts for the influence of pregnancy in exciting glycosuria.

The main *rôle* of carbohydrate in metabolism is to provide fuel for muscular energy and to provide for the complete combustion of other food-stuffs, particularly the fats.

The pancreas comes into activity when food is being prepared for absorption into the body; its external secretion is therefore pre-eminently concerned in the storage of energy; the internal secretion acts in the same direction. The pancreas is anabolic, and, like other anabolic activities, is controlled by the vagus, though not to the same extent as some of them. And as the vagus and the sympathetic are opposite in effect when supplied to the same structure, we should expect that the sympathetic would be inhibitory

to the pancreas as it is to other digestive processes. The antagonistic group, like other structures controlled by the sympathetic, comes into action when preparation is being made for display of energy.

Sympathetic stimulation is in the primitive state a preliminary to fight or flight. "Emotion moves us, hence the name," says Sherrington. Perhaps it would be more correct to say that emotion should lead to movement. But under conditions of civilisation the response to emotion tends to be repressed, while preparations for that response still occur. Among these preparations is the mobilisation of blood sugar, which is required for the anticipated display of muscular energy, since active muscle consumes three and a half times as much sugar as resting muscle.

Nervous energy tends to run in accustomed channels. Hence the influence of training. But this applies equally when the nervous energy is perverted; the emotional stimulus may persist because the natural response does not occur and the increased blood sugar becomes habitual.

It is clear, then, that anything diminishing the secretion of the pancreas or increasing the secretion of its antagonists will lower sugar tolerance and may excite frank glycosuria. Now any of the glands controlling carbohydrate metabolism may, of course, become the seat of organic disease. But in that case there will be other signs besides the effect on carbohydrate metabolism. If the pancreas be defective there will be fatty diarrhœa, and probably muscle nuclei and starch grains will be present in the stools. If its duct be obstructed, excess of its diastatic ferment will pass into the urine, where it can be identified. If its tissue cells are disintegrating, some of the products will also be found in the urine. The effects of hyperthyroidism are far-reaching and easily recognised. Over-activity of the pituitary may show itself in skeletal changes, polyuria and pressure effects on the second and third cranial nerves. Clinically we know less of over-secretion of the adrenals in disease, but we might expect it to be accompanied by general sympathetic irritation and raised blood-tension as well as by glycosuria.

It must be admitted that improved diagnostic methods of recognising signs of disease in these glands have not led to their being found in an increasing proportion of cases of clinical diabetes, although glycosuria may accompany organic disease of these glands. This led to the promulgation of the polyglandular hypothesis to explain diabetes. It was regarded as due to a "loss of balance between internal secretions." But how is such a loss of balance brought about? One can understand a loss of balance in a tripod if one leg is broken off. When one gland is diseased the antagonists will show relatively increased activity, just as a group of muscles will show contracture when their antagonists are paralysed. But when none of the glands are organically diseased, it seems to me that the only way in which a loss of balance can be produced is through a disturbed innervation. And it is clear that sympathetic irritation will at the same time diminish the activity of the gland which promotes sugar utilisation and increase the activity of the group of glands which throws sugar into the blood. In my Croonian Lectures I attempted to show by a lengthy chain of argument that no explanation of diabetes was adequate which left the sympathetic nervous system out of account.

Allen is one of the most recent and most convinced supporters of the pancreatic origin of diabetes. Yet even he admits that diabetes may proceed to a fatal issue and still leave the pancreas as good as normal. He is therefore obliged to postulate the existence of some nervous action, which is, as he says, more probably irritative than paralytic. Such an irritative action of the sympathetic would, as I have shown, supply the requirements of his postulate. As the effect of the sympathetic is less pronounced in diminishing the activity of the pancreas than in increasing the activity of its antagonists, it does not seem likely that its action would be confined to the pancreas, especially when we remember that the sympathetic nervous system is anatomically designed to produce wide-spread effects. Allen is opposed to the idea of an antagonism between the pancreas and the other group, although his own experiments appear to me to support that hypothesis.

Sympathetic irritation, then, means increased katabolism and diminished anabolism. And the new point we have learned about diabetes is that it is characterised by a wasteful metabolism. Now the quickest method of forcing metabolism to adopt economical lines is to cut off supplies. To realise this, one has only to note the quick fall of nitrogenous output as soon as no food protein is taken. Yet the old method of treatment in diabetes was greatly to increase the amount of protein in the food, thus throwing fuel into the flames. For excess of protein is a great quickener of all metabolic processes. One lesson we have all had to learn from the war is that we can balance our metabolism at a much lower level than we previously thought possible. And what may be but a passing phase for the normal individual must remain a permanent state for the diabetic. He must be permanently underfed. If he can balance his metabolism when the caloric value of his food is adequate to maintain life and a fair display of energy, the outlook is good; if he cannot acquire a balance until the intake is reduced too much for this, the outlook is bad. This is the *rationale* of the fasting treatment of diabetes. It is not difficult temporarily to rid the urine of sugar, but it may be difficult, nay impossible, to keep it free when the diet is increased to anything like the level to maintain life. It will be noted that this treatment does not attack the underlying cause of the disease, nor have we as yet any means of so doing. Indeed, the disease often progresses, though usually more slowly, during the

treatment. The value of intercalated fast days in the treatment of diabetes has been known for some years. It is the special merit of Allen's work that, starting from a fast, he systematically and cautiously re-educates the organism to metabolise more economically. He finds also experimentally that anything which diverts the energy of the pancreas from external secretion increases its capacity for internal secretion; conversely a strain thrown on its external secretory activity diminishes its internal secretory powers. This affords another reason for periods of alimentary rest.

Though Allen has naturally received the credit for the discovery of this method of treatment, we should not forget in this country that it was simultaneously discovered by Graham, while working in Garrod's wards at St. Bartholomew's Hospital. Unfortunately the war prevented any detailed publication by him. In essentials the two methods are the same, though Graham's is the less drastic and in my opinion is the less apt to disturb the general health. Many of us had been fumbling, with an inkling of the truth, along these lines, but to those two men must be accorded the credit for seeing farther into the heart of the problem. The results are shown in Poulton's Goulstonian Lectures. He finds that at Guy's Hospital, whereas formerly the mortality during the first year of the disease was 16·9 per cent., it is now only 5·4 per cent.; the average mortality rate of all cases admitted has been reduced from 23 per cent. to 7·7 per cent.; and whereas only 9·8 per cent. were formerly made free from sugar even for a day, now 73·5 per cent. can be rendered free for longer or shorter periods. Moreover, we have learned that coma is more generally due to faulty dieting with excess of protein and fat than an essential part of the disease.

MODERN METHODS OF TREATING FRACTURED FEMORA.

By W. ETHERINGTON WILSON,
Resident Medical Officer, 1st London General Hospital.

"To look back to Antiquity is one thing,
To go back to it is another."

THIS is written with a hope that those who have already seen a great deal of femur treatment during the war will not consider the subject rather an "ancient" one to bring up now. Much has been written and done in this direction during the last two years; but no doubt there are still many who have not had the opportunity of applying these recent methods, or seeing the results, and I sincerely hope that a few helpful hints and suggestions may be gleaned from this article by the latter. A knowledge of some good method of treatment is essential to prevent the avoidable disabilities and crippling which otherwise must often result. The H/S D. need no longer think himself unlucky when a fractured femur case falls to his lot, thanks to the excellent results which can be obtained, and can be shown in the special femur wards of the war, such as those at the 1st London General Hospital. Mr. Harold Wilson is responsible for the very good results obtained at the 1st London. Thanks are due to Major Sinclair, R.A.M.C., whose ingenuity and enterprise have been largely responsible for the improved procedure in treating fractured thighs.

I propose to deal in this Journal with the apparatus for, and the treatment of, a straightforward fracture in the middle of the femur.

A discussion will follow in a subsequent issue on points worthy of further consideration.

APPARATUS AND METHOD OF APPLICATION.

(1) *Thomas's knee-splint*, having a ring of sufficient size to easily fit the upper part of the patient's thigh. An average size is one having a circumference of 21 in. The very large sizes, *i.e.* 30 in., etc., used in this war should be abandoned, because they often cause deformity, are cumbersome and insanitary.

(2) *Glue.*—Composition recommended (Sinclair):—

Common glue	50 parts
Water	50 ,,
Glycerin	4 ,,
Calcium chloride	4 ,,
Thymol	1 part

The above when cool should be soft, flexible and elastic. The composition and treatment of the glue and the method of application to the leg is a most important matter, because on this knowledge the avoidance of future trouble depends, *e.g.* pain, blistering and slipping of the extension. The following points should help:

(i) Glue should just be brought to the melting-point by heating in a water-bath; it is then ready for use. The glue is spoilt by rapid melting and boiling.

(ii) The glue extension is applied to the limb between the knee and the ankle. Do not shave the leg. Apply glue all round the leg, upwards to within ¾ in. of a line around the limb at the level of the head of the fibula, downwards to a similar line 2 in. above the tip of the internal malleolus. When completely painted, finish off by stroking the hair in an upward direction.

(iii) Light threefold gauze 4 in. by 36 in. is next applied, one on each side of the glued leg, avoiding the crest of the tibia, but parallel to it.

(iv) Bandage to the limits of the glue by figure-of-8-method, commencing below. The first two turns of the bandage should not be tight; thereafter bandage firmly. These points are important.

The bandage itself should have a loose meshwork to allow the glue to settle in the meshes, thus further adding to the security of the extension. Pain and swelling of the foot does not occur because the bandaging is too firm; it is due to the first turn below being tight and cutting into the skin when pull is applied.

Adhesive-plaster strapping is not recommended. If used apply bandage in the same way.

(3) *Sinclair-footpiece.*—A flat wooden support which fits against the sole of the foot is most useful. It is kept in position as follows: The dorsum, sole and sides of foot are glued completely; flannel strands ¾ in. by 8 in. long are stuck on round the foot from the sole round to the dorsum, the ends of each strand not meeting in the mid-line by ¾ in. Each strand supports two metal rings (size of a shilling), the rings being placed on either side of the sole of the foot—*i. e.* six on each side. Tapes are tied to each ring. The tapes of opposite sides then embrace the foot-piece, which is thus held in position.

The latter is previously padded for the foot to rest comfortably on.

Objects of the foot piece:

(*a*) Adds to comfort of patient.

(*b*) Foot is steadied.

(*c*) Foot can be rotated outwards or inwards by moving the foot-piece.

(*d*) It can be converted into an extension when other methods have failed temporarily.

(*e*) Dorsi and plantar flexion of the foot are allowed at the will of the patient, thus preventing a stiff ankle.

The foot-piece is supported on the bars of the Thomas by a cross-bar which can be moved up and down, and held in position by a butterfly knut.

(4) *A square extension support* made of metal is tied on to the end of the Thomas, projecting downwards. The gauze extension is tied around this, and it serves to keep the extension off the ankles, thus avoiding discomfort.

(5) *A frame, eight pulleys, four bags* containing sand or shot and weighing six and eight pounds respectively. Lengths of *blind-cord.*

The pulleys and cord suspend the bags, which in turn suspend the Thomas and the limb.

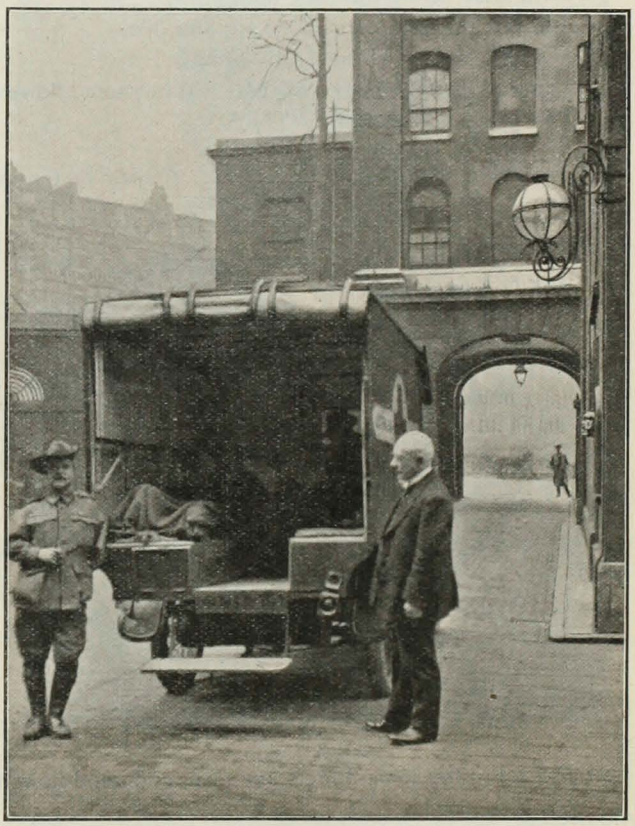
A frame made by Mr. Harold Wilson is used in the wards at Bart.'s. It is a small and useful modification of the Balkan frame.

Its objects are: (i) To support the Thomas. (ii) A sling over the middle beam enables the patient to lift himself as much as twelve inches off the bed, the foot of the sound leg being the only part actually touching the bed. Nursing is thus made easy. (iii) The middle vertical beam at the foot of the bed is the fixed point to which the Thomas is tied to get extension, as will be explained later.

(6) *Two blocks* to raise the foot of the bed. The height required varies with the case, 12 in. being an average amount.

In the special femur ward at the 1st London General Hospital the building is fitted up with overhead apparatus, serving the same purpose as described, except that the frame and other impedimenta are done away with. As a femur-ward is a war-time invention and does not come into civil practice it will not be described. The apparatus described can be seen in the wards at St. Bartholomew's Hospital.

(*To be concluded.*)



THE LATE STEWARD BIDDING FAREWELL TO THE LAST SOLDIER LEAVING THE HOSPITAL.

GAUDEAMUS IGITUR, OR VIEW DAY.

(*Four Sisters "in the Pink" round fire—first week in May.*)

1st P.S.: When shall we four be relieved,
In winter, summer, or in spring?

2nd P.S.: When the hurly-burly's done,
When the battle's fought and won.

(*Exeunt three P. Sisters. Third P.S. remains alone in room.*)

3rd P.S.: The earth will on itself but twice more turn
Before the Viscount, and the Governors will,
According to our ancient customs, come
And con the list of all the sick and suffering
Now lying in our ward. I know that some
Will never see another moon, and some
Must toss and moan long days and nights. But still
The Governors we will tell, that all within
The space of two weeks will be well.

(*4th P. Sister meditating in her room.*)

4th P.S.: The day is almost here—the dreadful day!
I will arise before the cock doth crow,
And risk the foul, contagious air, and, like
A wraith, with Franlink I will go into
The world's great mart, and there will buy some flowers
To decorate our hearth.

(*5 a.m.—Meets Staff-nurse in Square. Proceed to Covent Garden to buy flowers.*)

4th P.S.: 'Tis late. Let's stir ourselves, or soon the sun
Will find us out.

(*They meet colleagues from another ward.*)

4th P.S.: Good morning, friend! In "Faith," I had not thought
To meet, in such a place, a member of
The Great Retreat of Saint Bartholomew.

Sister "So": A greeting! "Mark" my words! I deeply fear
Our Matron none too pleased will be, that we
At such an hour have broke our bounds, and can
Near Covent Mart by all be found.

(*They separate and arrive at Covent Garden and buy flowers.*)

4th P.S.: Prithee some flowers, my man, and good flowers, too!
Some lilac and forget-me-nots.

S.-N.: These white and tender blossoms sure will make
A pretty setting for the mauve.

4th P.S.: Let's go. We have enough.

(*In Ward—late forenoon. View Day.*)

4th P.S.: The Ward is almost done. Two chairs are there
Before the hearth. Full many times have I
Been on the "mat"; but now, in one short hour,
A Viscount and the Matron too will sit
Upon my "mat."

th P.S.: Go, Nurse, put on your best attire.

Probationer: Now twice I've changed my stomacher and twice
I've changed my cap! When will it all be o'er?

4th P.S.: Now wheel this patient from the "front," and fill
His place with other from the "back." His knees
Are always up, and do upset the bed.

(*All Nurses in a line in Front Ward. Physicians and House-Physicians. 1st P.S. at end of Ward waiting to receive Governors.*)

4th P.S.: Hark! They come!

(*Looks towards screen at end of Ward.*)

4th P.S.: I feel an eye is peering from behind that screen!

(*Enter Viscount and Governors, preceded by Mace bearers Matron, Steward, Clerk to the Governors.* FANFARE OF TRUMPETS.)

Mace-bearer: The Viscount and the Governors!

(*Viscount shakes hand with Sister and Nurses. Viscount and Matron seated on hearth "MAT." Physicians and Governors grouped around. Physicians read out list of sick in Ward.*)

Physician: Now "One" has Rheúmatoíd Arthrítis,
And "Two" has Fíbroid Myócardítis, "Three"
Is suffering from Súppuratíve Phlebítis,
And "Four" Gastrítis has, while "Five" has got
A Mórbus Córdis with Aurícular Fíbrillátion.
Leukæmias and Anæmias, too, are here,
And Dropsy cases not a few; but all
Within ten days we will discharge!

Viscount: Pray, Doctors, do you find the Ward well to
Your liking!

Doctors: We do.

Viscount: The Sister and the Nurses too—do meet
With your approval?

Matron: They do.

Viscount: The patients, too, contented are, so we
Will go elsewhere! Adieu.

(*Exeunt Omnes.*)

FINIS.

G. W. T.

BACK FROM THE WAR.

BACK from the war, boy, and what saw you there?
Blood, death and laughter and men that would dare;
Strong hands of friendship and freedom from care.

What have you thought about, boy, who didst roam?
Food in the belly and love in the home;
Life, love and ale in the days that should come.

What was the war about, boy, after all?
The freedom of each and the freedom of all
To live to the best of us up to our call.

What have you learned, boy, and what do you see?
That the world's full of comrades as diff'rent can be;
And there's duty for them and there's duty for me.

J. R. R. T.

OBITUARY.

ARTHUR WATKINS.

THE Hospital has just lost a very highly valued officer in the death of its Steward, Mr. Arthur Watkins, in his 63rd year. On May 2nd he attended the funeral of Major Perrin, a former prominent member of the Resident Staff, at Weybridge. Upon leaving he had a cerebral seizure and passed away peacefully shortly afterwards.

Watkins was born in December, 1856, and entered the Clerk's Office in January, 1879, after having had some experience in a commercial house in the City. In June, 1887, he was appointed Assistant to the Steward (the late Mr. Mark Morris), and upon that officer's decease in November, 1895, was elected Steward. He had therefore completed forty years' service in the Hospital.

During this long tenure of office he was most devoted to the Hospital, and gave his best ungrudgingly to its service, for his heart was in his work.

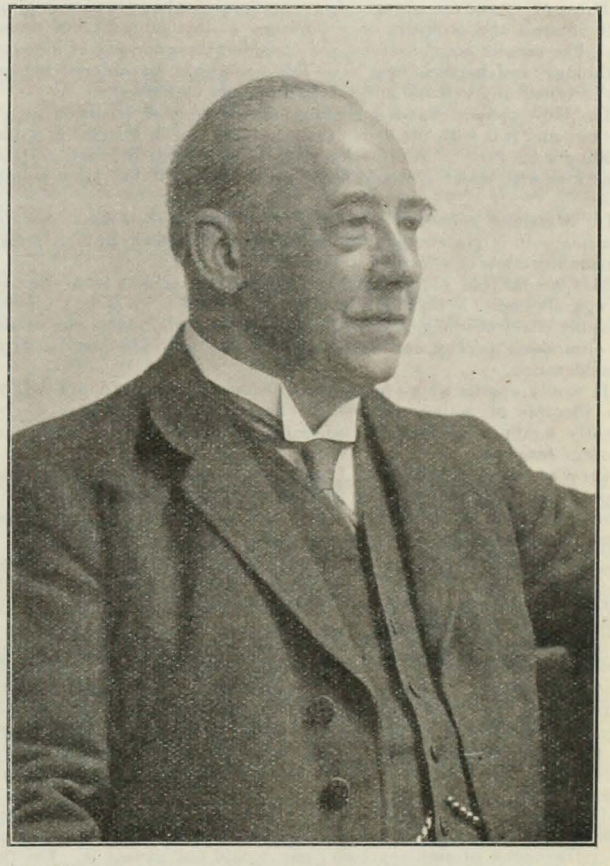
For the period of the war, when no less than 5406 patients were passed through the Military Wing of the Hospital, he was invariably present to receive the convoys of wounded as they arrived, and never failed to think of some means of adding to their comfort. His calm and placid demeanour during the numerous air raids to which London was subjected was of the greatest encouragement to patients and staff alike.

Visitors to the Hospital on our historic annual "View Day" considered it incomplete without a hand-shake and a few words with the popular Steward; and his presence was sadly missed this year in the official tour of the wards.

To those who sought his advice (which was always worth having) it was freely given, and in his quiet and unostentatious way he proved a good friend to many. His genial personality endeared him to everyone, and his loss will be keenly felt by all who knew him.

The writer cannot do better than quote Sir Norman Moore in his recently published *History of the Hospital.*

"And it is pleasant to know that this admirable old Steward (Mark Morris) would have thoroughly approved Mr. Watkins who was elected to succeed him in December 1895, and exactly resembles him in the qualities of invariable beneficence and untiring attention to every detail of his work."



THE STEWARD.

His recreations were foreign travel (when opportunity arose) and music, he having been the founder and Secretary of several choral and orchestral societies. In early life he was a conspicuous figure on the banks of the Lea as the popular and energetic secretary of a well-known rowing club.

He took keen interest in the Incorporated Association of Hospital Officers, having been a member since its foundation in 1902, and its President for the year 1914–15. He was also a member of the Dickens Fellowship Club and the City Temple Literary Society.

The large attendance of Governors and members of the various staffs of our own and other hospitals at the funeral service, held in the Church of St. Bartholomew-the-Great on May 7th, testified to the esteem in which he was held.

J. S. S.

CORRESPONDENCE.

PROTEIN SHOCK AND INTRAVENOUS VACCINE THERAPY.

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

SIR,—Dr. Gow's paper on "Protein Shock and Intravenous Vaccine Therapy" is of such interest that I hope he may be induced to write more upon the same subject.

Those of us who are engaged in general practice have been watching with interest the progress of experience in this subject; but those who, like myself, are conscious of a considerable ignorance of modern pathology and bacteriology have felt somewhat bewildered before the information available and the terminology employed.

Dr. Gow's paper shows a striking marshalling of recorded experience; and it is with the belief that the clinician in general practice is hungry for further information that I venture to indicate certain questions with which it would be of great interest if Dr. Gow would deal.

(1) *Material employed for inducing the intravenous protein reaction.*—It is stated that the reaction is "induced by the intravenous injection of a foreign protein."

May we be told of the observed effects consequent upon the use of egg-albumen? In this way a simpler issue is involved; for the possible effect of other bodies contained in bacterial emulsions would be eliminated thereby, and one thing at a time would be presented for consideration.

It would appear by no means impossible that much (if not all) of the theories of active and passive immunisation may have to be greatly modified as further knowledge is gained in the subject of protein reaction.

(2) *The words "sensitised" and "desensitised."*—Is there any explanation of the processes of "sensitisation" and "desensitisation"? The application of the former word both to the patient and to the agent introduced into him is to me a puzzling use of words.

(3) *Intravenous and intradermal.*—(*a*) What is the explanation of the difference in reaction caused by "intravenous" and "intradermal" injections of sera and vaccines? (It would appear to be unconnected with dosage.)

(*b*) In the case of anti tetanus serum, a very small proportion of patients have exhibited a reaction which has been often described. Is this anaphylactic? Is it a protein reaction? I have many times given it to patients who have had previous injections after intervals of two years and upwards, and have seen no reaction. This serum is not given intravenously. What is the essential difference in the disposal by the body of intravenously and intradermally given sera respectively?

(*c*) In the case of "anti-typhoid vaccine" (T.V. and T.A.B.), the reaction for the most part bears no resemblance to the clinical picture of intravenous protein reaction; one would not expect it. On the other hand, I have seen two cases (of which I was one) having a very striking resemblance thereto—extreme suddenness of onset, rigor, nausea, vomiting, headache. These injections were not intravenous. Were they cases of protein reaction?

(4) The difference in the behaviour of the body to intravenous and to intradermal injections of sera respectively seems to be a subject of the greatest interest, and may lead to the advancement of our knowledge as to the causation of certain obscure diseases, and of our knowledge of the behaviour of injured tissues.

(5) A most interesting and suggestive article by Dr. Clive Riviere appeared (I think in the *Brit. Med. Journ.* in 1908 or 1909) on "Auto-inoculation in Medicine"; some of the theories put forward therein may come into contact with this knowledge of protein reaction now being gained.

(6) The subject appears to me to be of the greatest interest and importance to medicine, and my gratitude to Dr. Gow for his paper includes a hopeful anticipation of further papers to come.

I am, Sir,
Your obedient servant,
J. R. R. TRIST,
Lieut.-Col., R.A.M.C. (S.R.),
commanding 2/2 Wessex Field Amb.,
B.E.F., France.

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

SIR,—You have kindly allowed me to see Col. Rigden Trist's letter in advance so that there may be less delay in reply. But it needs a far abler pen than mine to furnish explanation of the various and interesting phenomena to which he refers, and the *rôle* I have tried to fulfil so far is that of a recorder only, and it is unwise for me to attempt to overstep that at present.

With regard to his first point, I have no personal experience of the intravenous injection of egg-albumen. To obtain a satisfactory therapeutic effect when a foreign, non-specific protein is employed, *i.e.* when an autogenous vaccine is not used, it appears to be essential to produce a brisk reaction with a temperature of 104° F. or so. This result is obtained with great constancy by the use of an emulsion of *B. coli* or *B. typhosus*, and as either is easy to procure and simple to handle it is most frequently employed.

(2) It is indeed unfortunate that the terms *sensitisation* and *desensitisation* have been applied to both patient and vaccine, for the meaning in each case is entirely different. A *patient* is said to be *sensitised* to a particular protein when he has been rendered *hypersensitive* to it by an injection of that protein, that is, when a second small dose of that same protein causes him to react in a certain peculiar fashion—the so-called "anaphylactic shock." *Desensitisation of a patient* is the process whereby this state of anaphylaxis is rendered of no account and the patient become "anti-anaphylactic." A *sensitised vaccine* is an emulsion of the organism which has been in contact with specific anti-serum, whereby union of antigen (bacterium) and antibody (in the serum) has been brought about. A sensitised vaccine has the advantage over a plain emulsion in that it is less toxic, can be given in larger doses, the production of immunity is accelerated, and the "negative phase" is eliminated or greatly diminished.

3. (*a*) It is possible that the difference in reaction caused by the *intravenous* and *subcutaneous* injection of sera and vaccines depends in the main on the rapidity with which these substances reach the blood-stream. In the former it is instantaneous, producing a relatively brisk response; in the latter absorption takes place slowly, and the effects are relatively mild and spread over a longer period. The *intradermal* route is employed as a test for anaphylaxis only, as it yields a visible result.

(*b*) A reaction following second doses of anti-tetanus serum may be either serum sickness or anaphylactic shock. The majority of patients, fortunately, is not rendered anaphylactic by one subcutaneous injection of serum.

(*c*) When giving what is intended to be a subcutaneous injection of vaccine it is possible that on rare occasions the needle may pierce a small vein in the tissues, with the result that all, or part, of the dose enters the vein. This seems to me a likely explanation of Col. Trist's experience, for the sequence he describes is typical of the intravenous protein reaction.

I am grateful to Col. Trist for his letter, and wish I could more satisfactorily answer his questions. It seems my remarks may have stimulated an interest in this subject, and I hope others may be induced to work at it and record their experiences.

I am, Sir,
Yours faithfully,
A. E. GOW.

37, QUEEN ANNE STREET, W. 1;
May 12th, 1919.

RECONSTRUCTION.

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

SIR,—Having read with much interest the articles on reconstruction appearing in your last issue, I would like to draw attention to what seems a deficiency in the Hospital's present organisation. To my mind there is required a proper "Follow-up" Department—such as exists in most American clinics, and which could be readily instituted at "Bart.'s," and this at very little expense.

All that is needed is a card-index system, and a clerk to send letters to ex-patients, or their doctors, inquiring about their progress, etc., or inviting them to attend and interview the physician or surgeon who treated them. Such a department might be controlled by one of the Medical or Surgical Registrars, who would note down the results of inquiries and interviews on special "follow-up" forms.

These could then be bound with the case-notes or in a separate volume.

At present final results are unknown, for as it is the student sees very few complete cases, excepting those in a room on the top floor of the Pathological Block. Others are probably forgotten; for example, he never knows if the man whose semilunar cartilage he saw removed, or the subject who underwent a gastro-enterostomy, remained cured of his symptoms a year or two later.

In the wards one learns much diagnosis but very little prognosis, —the latter a much more difficult subject and one of supreme importance to the general practitioner.

I am, Sir,
Yours faithfully,
A. D. WALL,
Temp. Surgeon-Lieut., R.N.

May 16th, 1919.

THE TREATMENT OF AMŒBIC DYSENTERY.

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

SIR,—I have read with considerable surprise a paper in your current issue by Capt. Prall, R.A.M.C., on the treatment of amœbic dysentery.

The treatment of dysentery by heroic doses of ipecacuanha was a horrible one even in the days when such a course was necessary; now that more efficient drugs are at hand it is positively barbarous. If the drug must be given by the mouth, it is surely better in the form of the double iodide of bismuth and emetine in, say, gr. ij doses. This, if given as a pill coated with salol, seldom causes vomiting, and never seriously interferes with the nutrition of the patient.

In regard to the question of hypodermic injection of emetine, I have used the drug since it was first introduced, and have given several thousand injections. I have never seen a patient upset by it, and I believe this only occurs when excessive doses are used or the administration of the drug is continued too long without a break. I think Capt. Prall must seek some other cause for the D.A.H.

Capt. Prall says that "it is essential that the injection should reach the cæcum," but, apart from the fact that dysenteric ulcers may be found post-mortem in the lower part of the ileum, one fails to see how an enema of 8 oz. is ever going to reach the cæcum. If Capt. Prall will, on the X-ray table, inject an enema of this amount containing a radio-opaque substance, I think he will convince himself of the difficulty.

There is no proof brought forward in this paper that any case of a dysentery carrier can be cured by this method, and these are the only cases that really cause any difficulty to the physician.

My own experience is that gr. iij of the double iodide of bismuth and emetine given for a period of twenty-one days, then omitted for fourteen, and subsequently repeated if required, will cure all but a very small number of carriers, the results having been checked over a considerable number of weeks. Possibly Lambert's method—double iodide gr. ij at night and emetine hypodermic gr. j in the morning—is better still.

I am, yours, etc.,
JAMES L. MAXWELL,
Major, R.A.M.C.

GRAYLINGWELL WAR HOSPITAL,
CHICHESTER;
April 12th, 1919.

REVIEWS.

PYE'S SURGICAL HANDICRAFT. Enlarged and largely re-written by W. H. CLAYTON-GREENE. Eighth Edition. (John Wright & Sons, Ltd.) Pp. 639. Price 21*s.* net.

We have always regarded this work as one of the most practical and useful compilations from the point of view of the dresser, and particularly the house-surgeon. The book is extremely well printed and illustrated, and constitutes a veritable store of practical information. Several sections of the book are written by specialists in that particular subject; thus, the chapter on "Poisoning" is in the capable hands of Dr. W. H. Willcox, while Dr. Joseph Blomfield is responsible for the short chapter on "Anæsthesia."

The present edition has been thoroughly revised and includes much new matter, a notable addition being the details for the treatment of orthopædic cases.

We have every confidence in recommending the volume under review; it is a book which should be in the hands of every student.

AIDS TO SURGERY. By JOSEPH CUNNING and CECIL A. JOLL. Fourth Edition. (Baillière, Tindall & Cox.) Pp. viii + 420. Price 4*s.* 6*d.* net.

This most excellent little volume is deservedly one of the most popular of the "Aid" Series. It may be described as an admirable epitome of surgery. The present edition has been almost entirely revised by Cecil A. Joll, who is to be congratulated on his efforts to include the latest advances in military surgery.

The R.A.M.C. officer returning from the Front will find this little volume most useful in enabling him to review rapidly a subject which in a great number of cases unfortunately has had to be neglected. From the point of view of the student the book will prove equally valuable for revision purposes.

THE AFTER-TREATMENT OF WOUNDS AND INJURIES. By R. C. ELMSLIE, M.S., F.R.C.S. (J. & A. Churchill.) Pp. 319. Price 15*s.* net.

The author of this illuminating work needs no introduction to our readers. Mr. Elmslie for several years has done most valuable work in charge of the Orthopædic Department of this Hospital. During the war he has also been connected with a special military orthopædic hospital, and it is largely the results of the experience acquired during two and a-half years in this latter establishment which go to make up the volume.

Three principles underlie orthopædic surgery: a knowledge of pathology, a clear appreciation of mechanics, and the realisation that the surgeon's aim is to restore function; and while many new methods have appeared in military orthopædics the principles are the same in civil practice.

The book is divided into nineteen chapters and embraces every branch of this most important aspect of surgery. An interesting chapter is devoted to the rational treatment of chronic sinuses of bone, the author strongly advocating the radical operation as performed by Prof. Broca. The chapters devoted to methods of splinting, physical methods of treatment and plaster-of-Paris work are exceptionally valuable, representing as they do the results of a unique experience. Other chapters deal with injuries to specific regions, and contain many examples of actual cases.

The book contains a large number of illustrations, some of which, we regret to say, appear to have suffered somewhat in reproduction. Otherwise the book is excellently done, and both author and publishers are to be congratulated on the production of a work of the very highest order.

LEWIS'S MEDICAL AND SCIENTIFIC LIBRARY. (H. K. Lewis & Co., Ltd.) Pp. 492. Price 12*s.* 6*d.* net. To subscribers 6*s.* net.

Lewis's Library is one of those valuable institutions which the medical student soon learns to regard as a practical necessity. This excellently bound catalogue gives a complete list of books available, the present edition having been revised to the end of 1917. A classified index of subjects with the names of those authors who have treated upon them has also been included, and adds considerably to its usefulness.

AIDS TO HISTOLOGY. By A. GOODALL. (Baillière, Tindall & Cox.) Second Edition. Pp. viii + 135. Price 3s.

While this book may prove of value in revising the histology of the various tissues and organs of the body, we cannot say that we are greatly impressed. It does not differ materially from the first edition published in 1911. Obviously in a book of this size it is not possible to include many illustrations, which in a book on this subject would appear to be an essential feature, and we think the student would be well advised to concentrate on some of the larger books dealing with this branch of microscopical work.

EXAMINATIONS, ETC.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

May, 1919.

W. D'Este Emery has passed the Examination for Membership.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Final F.R.C.S. Examination, May, 1919.

T. H. Just, R. E. T. Tatlow, H. B. G. Russell, L. G. Phillips, R. O. Ward, M. W. K. Bird.

Primary F.R.C.S. Examination, May, 1919.

Special Examination.—W. Briggs, E. I. Lloyd, J. Mc.L. Pinkerton, *Ordinary Examination.*—F. C. W. Capps, H. L. Sackett, S. R. Simaika, W. E. M. Wardill, E. H. Weatherall.

CONJOINT EXAMINING BOARD.

First Examination, March, 1919.

Part I. Chemistry.—H. C. M. Williams, A. Jephcott.

Part II. Physics.—H. C. M. Williams, A. Jephcott, D. H. Cockell, W. M. Jones.

Part III. Elementary Biology.—H. C. M. Williams, S. Jenkinson, H. V. R. T. Lauder, M. H. Mehliss, H. H. D. Sutherland, G. Elliot.

Second Examination, March, 1919.

Anatomy and Physiology.—G. Kinneir, S. Gordon, T. J. D. Atteridge.

Final Examination, March, 1919.

The following have completed the Examination for the Diplomas of M.R.C.S. & L.R.C.P.:

J. N. Leitch, P. B. Kittel, C. W. Bennett, W. S. Sykes, J. L. Nisbet, E. D. Macmillan.

CHANGES OF ADDRESS.

BECKTON, H., 57, Goldington Road, Bedford.
CANE, L. B., Capt. R.A.M.C., Burma Mines Ltd., Namtu, Northern Shan States, Burma.
CARVER, A., 35, Paradise Street, Birmingham.
DRAWBRIDGE, W. R. L., Lancing College, near Worthing, Sussex.
GRIFFITH, H. K., Roydon, Ashelton Road, Torquay.
HAMILL, J. M., 5, Avonmore Mansions, Avonmore Road, West Kensington, W. 19.
HAMILTON, W. G., Maj. I.M.S., Presidency Jail, Alipore, Calcutta.
HARKER, T. H., 18, Queen's Road, Southport, Lancs.
HAY, K. R., 47, Hill Street, Berkeley Square, W. 1. (Tel. Mayfair 5768.)
HUDSON, B., Palace Hotel, Montana s. Sierre. (Valais.)
HUGHES, G. S., 6, St. Leonards, York.
LEGG, J. WICKHAM, 82, Woodstock Road, Oxford.
OLIVER, M. W. B., 128, Harley Street, W. 1. (Tel. Mayfair 4188.)
PARKER, H. F., The Turret House, Guildford.
ROBINSON, C. A., Brookside, Beaufort Road, Llandrindod Wells.
ROXBURGH, A. C., 31, New Cavendish Street, W. 1. (Tel. Mayfair 4764.)
SHAW, H. C. C., Charleville, Queensland, Australia.
SLOMAN, H., c/o 39, West Street, Farnham.
WHARRY, H. M., 54, Beaumont Street, W. 1.

Dr. OSKAR TEICHMANN, of "Sitka," Chislehurst, has by deed poll, dated the 12th day of May, 1919, changed his name to Dr. OSKAR TEICHMAN.

APPOINTMENTS.

BROCKMAN, R. St. L., M.R.C.S., L.R.C.P.(Lond.), appointed R.S.O., The Royal Infirmary, Sheffield.
EVANS, D. B., M.R.C.S., L.R.C.P., appointed Medical Superintendent, North Wales Sanatorium, Llanguyfan, near Denbigh.
MAXWELL, J. P., M.D.(Lond.), F.R.C.S., appointed Professor and Head of the Department of Gynæcology and Obstetrics at Union Medical College, Rockefeller Foundation, Pekin.

BIRTHS.

HAY.—On May 25th, at 47, Hill Street, Berkeley Square, W. 1, the wife of Kenneth R. Hay, M.B., of a daughter.
QUICK.—On May 12th, at 137, Walter Road, Swansea, to Ruth (*née* Hellins), wife of Dr. Hamilton Quick—a daughter.
SQUIRE.—On May 11th, at Firbank, Hythe, to Dorothy (*née* Walter), wife of Lieut. H. F. Squire, R.A.F., M.S., the gift of a son.
RAMSAY.—On May 13th, at 4, Bryanston Street, W., the wife of Robert A. Ramsay, of a son.
WATERFIELD.—On April 4th, at Port Sudan, to Noël E. Waterfield, M.B., B.S.(Lond.), F.R.C.S., and Mrs. Waterfield—a daughter.
WHITE.—On May 10th, at 1, Albemarle Road, Withington, Manchester, the wife of Dr. C. Powell White—a son.

MARRIAGES.

BACKUS—ELSON.—On May 14th, at Savoy Chapel, Dr. C. H. Backus, R.A.M.C., to Gertrud Marion Elson.
SHAH—SHAH.—At Poona (India), on February 27th, 1919, while on leave from Palestine, Capt. J. M. Shah, I.M.S., E.E.F., with Shahunshah Begum, daughter of Capt. Cassem Shah, 3rd Skinner's Horse, Indian Army.

DEATHS.

BAILEY.—On April 13th, 1919, in German East Africa, James Connor Maxwell Bailey, O.B.E., M.D.(Lond.), Principal Medical Officer in German East Africa, aged 40.
BATEMAN.—On April 9th, 1919, after a short illness, Alfred George Bateman, M.B., C.M.(Aberd.), Secretary of the Medical Defence Union.
STURDY.—On May 1st, 1919, at the Colabar Hospital, Bombay, of dysentery, while on active service, Arthur Carlile, M.C., F.R.C.S. (Eng.), Temp. Capt. R.A.M.C., and practising at Horsham, second son of Rev. H. C. Sturdy, aged 36.

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.

St. Bartholomew's Hospital Journal.

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

VOL. XXVI.—No. 10.] JULY 1ST, 1919. [PRICE SIXPENCE.

CALENDAR.

Fri.,	June	27.—Dr. Tooth and Sir D'Arcy Power on duty.
Tues.,	July	1.—Sir Archibald Garrod and Mr. Waring on duty.
Fri.,	,,	4.—Dr. Calvert and Mr. McAdam Eccles on duty.
Tues.,	,,	8.—Dr. Fletcher and Mr. Bailey on duty.
Fri.,	,,	11.—Sir Wilmot Herringham and Sir Anthony Bowlby on duty.
Tues.,	,,	15.—Dr. Tooth and Sir D'Arcy Power on duty.
Wed.,	,,	16.—**Summer Session ends.**
Fri.,	,,	18.—Sir Archibald Garrod and Mr. Waring on duty.
Tues.,	,,	22.—Dr. Calvert and Mr. McAdam Eccles on duty.
Fri.,	,,	25.—Dr. Fletcher and Mr. Bailey on duty.
Tues.,	,,	29.—Sir Wilmot Herringham and Sir Anthony Bowlby on duty.
Fri.,	Aug.,	1.—Dr. Tooth and Sir D'Arcy Power on duty.

EDITORIAL NOTES.

WE are indeed sorry to hear that Sir Anthony Bowlby, K.C.B., K.C.M.G., K.C.V.O., is about to retire from the active service of the Hospital.

There are many old St. Bartholomew's men who owe a great deal to Sir Anthony, both as his pupils and as practitioners afterwards, and we are glad to see by a letter which will be found in this JOURNAL that an opportunity has been given to all Hospital men to subscribe towards a portrait of him, which shall be hung in the Great Hall of the Hospital.

It is some long time since a member of the Staff has been honoured in this way, and we are quite sure there is no more outstanding figure in the life of the Hospital during late years who deserves the honour more than Sir Anthony.

We wish the scheme every success.

* * *

The occasion of the Mid-Sessional Address before the Abernethian Society on June 19th was in every way reminiscent of pre-war days.

Sir Anthony Bowlby had consented to speak on "The Development of Front-line Surgery in France," and the result was one of the best addresses we have been privileged to hear in our familiar lecture theatre.

For over an hour Sir Anthony spoke without notes, his delivery and diction being perfect. Many of us realised for the first time how much the country really owes to the organising efforts of our Senior Surgeon, and never has the Hospital been more proud of its distinguished representative.

We hope to publish a report of Sir Anthony's address in our next issue.

* * *

The results in the Final London M.B. Examinations as usual are very complimentary to the Hospital. We cannot let the occasion pass, however, without specially congratulating Mr. R. J. Perkins on his magnificent effort. Not only has he gained the Gold Medal, but in addition is distinguished in Forensic Medicine, Medicine and Surgery. With one possible exception, we believe, this constitutes a record for the Hospital.

The results in the Final Examination for the Fellowship of the Royal College of Surgeons are also creditable, six out of the fifteen successful candidates being Bart.'s men.

* * *

The revival of the Past and Present Cricket and Tennis Matches at Winchmore Hill was a success in every way. We are publishing elsewhere the scores, although, to be perfectly frank, the cricket was quite a secondary feature compared with the most excellent tea and the delightful music of the Artists' Rifles' band.

We were very pleased to see so many members of the Senior Staff present.

* * *

It will no doubt interest our readers to learn that Dr. C. S. Myers, F.R.S., Director of the Cambridge University Laboratory of Experimental Psychology, has been elected a Fellow of Caius College.

* * *

As a result of the Hospital Dance, we understand that exactly £100 will be handed over to the Fund for the

New Home for the Nurses. We congratulate all concerned on this very pleasing effort.

* * *

Lieut.-Col. W. McAdam Eccles has been appointed Surgical Adviser to the Headquarters (A.M.S.) Appeal Board, War Office.

* * *

Our heartiest congratulations to the following members of our Hospital Staff whose names appear in the Birthday Honours. The awards are as follows:

K.C.B.—Temp. Maj.-Gen. Sir A. A. Bowlby.
K.C.M.G.—Temp. Maj.-Gen. Sir W. P. Herringham.
K.B.E.—Lieut.-Col. D'Arcy Power.
„ Temp. Col. C. Gordon Watson.
C.B.E.—Temp. Lieut.-Col. Sir Robert Armstrong-Jones.
„ Lieut.-Col. J. Calvert.
„ Temp. Hon. Lieut.-Col. M. H. Gordon,
„ Capt. (Act.-Maj.) R. M. Vick.
O.B.E.—Maj. F. W. Andrewes.
„ Capt. and Brevet-Maj. R. C. Elmslie.
„ Temp. Capt. (Act.-Maj.) J. E. H. Roberts.
To be Brevet Lieut.-Col.—Maj. W. McAdam Eccles.

In addition to the members of the Staff, a very large number of Bart.'s men are included in the Birthday Honours. Owing to the lack of space it is not possible to include the list in this issue, but we hope to do so in the August number.

* * *

The Blakeway Memorial Fund is making steady progress, and donations now arriving from abroad show that the appeals which have appeared in these pages are gradually reaching out-lying friends keen to testify their admiration for the man and his work. Poignancy is now given to these appeals by the notice, appearing in another column, of the birth of a posthumous child. Further contributions to the Fund will be welcomed by Capt. A. Macphail, Treasurer, Anatomy Department, or Mr. R. M. Vick, Secretary, Pathology Department.

* * *

We regret to hear of the death of Mr. Edgar Duncan Macmillan, M.R.C.S., L.R.C.P., who was a student here for the past three years, having qualified quite recently. He was taken ill with cerebro-spinal meningitis on May 2nd, just a fortnight after passing his final examination, and died three weeks later on May 23rd in York Military Hospital.

Macmillan was in his twenty-fifth year and the only son of Major J. M. Macmillan, R.A.M.C. Headquarters, Northern Command, York, and was educated at the High School, Glasgow, his father being in practice in that city at the time.

He intended to take a degree in science before proceeding to his medical course, but over-study leading to ill-health he accompanied his parents to British Columbia, Canada, in 1910. They returned to England after five years of an open-air life which put him on his feet again. Macmillan became a medical student at this Hospital early in 1916, and by dint of hard study he passed the Conjoint Examination in the minimum regulation period. While at Bart.'s he made several friends, was respected by all his colleagues, and his conscientious work in his clinical appointments was far above the average. So keen was he in his desire for knowledge and experience that during his vacations from Bart.'s he acted as house-surgeon at the County Hospital, and assisted at the Military Hospital, York.

He was buried at Berkswich, Stafford, near the residence of his fiancée, Miss Burton, to whom, as well as his parents and sister, we extend the sincerest sympathy in their bereavement.

THE BOWLBY PORTRAIT FUND.

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

DEAR SIR,

Sir Anthony Bowlby will shortly retire from the Staff of the Hospital. It is proposed to present him with a portrait of himself, painted by a well-known artist, as a recognition not only of his services to the Hospital and Medical School of St. Bartholomew, but also as an appreciation, which all Bart.'s men must feel, for the great work that he has done in connection with the A.M.S. during the war. It is felt that all those who have come in contact with him either directly or indirectly would like to subscribe towards such an object, and therefore the notice has been circulated to all old Bart.'s men and students inviting them to do so.

A certain number of these notices have been returned to me owing to the fact that we have some incorrect addresses. I should not like to feel that there may be some who would wish to subscribe and have not received this notice, and am therefore asking you whether you would be as good as to place this letter in the JOURNAL.

It is hoped that all those who are intending to subscribe will do so as soon as possible so that arrangements may be made in selecting the artist who is to make the portrait, as this will largely depend upon the amount of money obtained. It is hoped that we shall be able to employ the services of the best artist possible.

When the portrait is painted it is intended that a meeting should be held to present the portrait to Sir Anthony, together with a list of the subscribers. The permission of the Treasurer and Almoners has been given that the portrait should be hung in the Great Hall of the Hospital amongst those of his illustrious predecessors which already adorn it.

Subscriptions, which should not exceed two guineas,

should be sent to Mr. R. Cozens Bailey at the accompanying address, who will act as Hon. Treasurer of the Fund.

Yours sincerely,

W. GIRLING BALL,

Hon. Sec.

Bowlby Portrait Fund.

WARDEN'S HOUSE,
ST. BARTHOLOMEW'S HOSPITAL AND COLLEGE,
LONDON, E.C.;
June 12th, 1919.

MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

(*Continued from p.* 104.)

DISEASES OF THE STOMACH.

(101) Dilatation of the stomach is not in itself an indication for gastro-enterostomy. The indication for this procedure in a case of dilated stomach is pyloric obstruction, and in proportion to the degree of this defect which is present in any particular case will benefit follow the operation. If the case is one of primary "atonic" dilatation with ptosis, the result of short-circuiting the pylorus is nearly always disappointing, and not infrequently harmful.

(102) Pain is sometimes the sole symptom in a case of duodenal ulcer, and yet, if the pain have certain characters, a diagnosis may be made with considerable confidence. Much more hesitation is called for in the diagnosis of cholecystitis in similar circumstances. *In appendicitis it is doubtful if a diagnosis based upon pain alone is ever justified.*

(103) Cardiospasm occurs under three different conditions: (i) in association with gastric "hyperacidity" and flatulence; (ii) as a neurosis; and (iii) in association with cancer of the cardiac end of the stomach. (i) is quite common; a point of importance in connection with it is that, if the pain be severe, which it not seldom is, and if the symptoms referable to the stomach be not very apparent, which they may not be, the source of the pain may be considered to be the aorta, and the pain may be thought to be anginal in character. (ii) occurs in women, usually about middle age; it leads eventually to loss of flesh, even to emaciation, and eventually to dilatation of the œsophagus; the patient often finds that she can swallow her food with relative comfort if she takes her meals alone. In (iii) the pain is usually much less severe than in (ii) and (i), and its occurrence is less erratic.

(104) Peptic ulcer is not cured by an operation performed to short-circuit it, and the surgeon who allows his patient to think so is either careless of the latter's welfare in the future, or learns nothing from experience. A short-circuit drains the stomach, allows physiological rest to the organ, facilitates healing of the ulcerated surface, and enables the patient to get much better results from appropriate changes in his diet and habits than he can do without these helps. *The operation should be regarded as being the first step in treatment, and not the last.*

(105) Anorexia is an important, and often a very early, symptom in cancer of the stomach. It is also an important symptom in the differential diagnosis of this disease from simple ulcer, in which disease, though the appetite is often capricious (and sometimes excessive) it is rarely absent.

(106) A helpful point in the differential diagnosis of simple as against malignant pyloric obstruction is the condition of the blood: in simple obstruction, whatever the degree of emaciation—and this may be considerable—anæmia does not occur, whereas in obstruction due to cancer anæmia is almost invariable and may be very marked.

(107) It is commonly taught that cancer of the stomach is usually preceded by such predisposing causes as gastritis, simple ulcer, etc., and that cancer of the colon is preceded by constipation. The doctrine would seem to be based upon pure supposition, for though it is certain that in a few cases carcinoma supervenes upon chronic gastric ulcer, it happens much more frequently that the subjects of cancer of the stomach have been free from all forms of dyspepsia until the time the growth develops. The disease comes, as it were, "out of the blue." Similarly with cancer of the colon, more often than not the patient's first experience of troublesome constipation synchronises with the development of the carcinoma. Moreover, both gastric dyspepsia and (especially) constipation are more common in females than in males, whereas the reverse is the case with cancer of the stomach and with cancer of the colon.

(108) Cancer of the stomach developing in a woman who is the subject of marked gastroptosis may yield a mass which is felt in the neighbourhood of the umbilicus. In these circumstances, despite the apparently bad prognosis indicated by the presence of a tumour, and by its size, an exploratory laparotomy should be undertaken, because this position of the growth is relatively favourable for complete removal. Such cases provide some of the few radical cures that have followed surgical treatment in this disease.

(109) *The only hope of radical cure in cancer of the stomach is afforded by very early diagnosis.* On no account should the observer wait for the development of a tumour. If a case of gastric dyspepsia, on the evidence available, is considered to be of this nature, and if the patient continues to lose weight after fourteen days of observation in bed, with careful feeding, it is a sound proceeding to explore the stomach with a view to excision of the growth.

DISEASES OF THE LIVER.

(110) In palpation of the liver it is well to adopt a definite method. Perhaps the following is as good as any: (i) *Find the lower border and trace its outline.* In doing this, care should be taken to begin the palpation sufficiently low down to ensure not missing the edge of an organ that is larger than was anticipated. If this precaution be not adopted, and the surface of the liver happen to be smooth, it is not unlikely that the observer will report that the lower border of the liver cannot be felt. This error is avoided by beginning to palpate in the right iliac fossa and proceeding gradually upwards. (ii) *Ascertain the characters of the lower border*—? thin or thick, ? regular or irregular, ? normal consistency or hard, ? everted. (iii) *Explore the anterior surface* of the organ for uniformity or lack of it, and for the number and size of any irregularities, with any special feature these may possess, *e.g.*, umbilication (iv) *Judge of the massiveness of the organ*, using the bimanual method, which has also been employed in (i) and (ii). (v) *Judge also of the degree of fixation of the organ* by bimanual palpation when the patient is in the genu-pectoral position.

(111) There are three stages in the course of alcoholic cirrhosis of the liver: portal congestion, portal pressure, and cholæmia. In the first stage the symptoms are chiefly those of chronic gastritis, and physical signs are, for the most part, absent. The symptoms and signs during the second stage are chiefly referable to the collateral portal circulation. The symptoms of the third stage are toxic, and are analogous to those met with in icterus gravis. But in most cases this third stage never arrives, because the patient succumbs to one or other of the serious complications of the second stage (hæmatemesis, portal thrombosis, heart failure), or to one of those infective processes to which the patient is specially liable (tuberculosis, streptococcus and pneumococcus infection).

(112) Hæmatemesis in cirrhosis of the liver may occur during the stage of portal congestion, in which case the bleeding is due to more or less general oozing from the congested gastric mucosa and is not of serious consequence; or it may occur during the stage of portal pressure (collateral portal circulation), when the blood usually comes from an ulcerated varicose vein at the lower end of the œsophagus and is of very serious significance. If this distinction can be made clearly in any particular case, the treatment is considerably helped. In the early type of hæmorrhage portal depletives may be used freely with advantage; in the later type the treatment should be on the lines adopted in the hæmatemesis of gastric ulcer.

(113) The state of compensation which is seen in many cases of cirrhosis of the liver during the second stage may be maintained at a fairly good level for several years, provided the patient gives up all or most of his alcohol and adopts a simple dietary. This condition of things is rarely seen in hospital practice—a fact which explains the bad prognosis in respect of time given by many authors in this disease.

(114) The distinction which has been made between cirrhosis of the liver and perihepatitis in regard to ascites—namely, that when ascites recurs several times after paracentesis the pathological condition present is perihepatitis and not cirrhosis—is probably much too arbitrary. It is doubtless true that, *cæteris paribus*, perihepatitis is more constantly followed by ascites than is cirrhosis of the liver; but it is also true that recurring ascites not seldom complicates cirrhosis in the absence of perihepatitis.

(115) *Fever is common in cirrhosis of the liver, but the cause of it is by no means always apparent.* Serious causes that should be passed in review are pleural, pulmonary and peritoneal tuberculosis, septic pylephlebitis and cholecystitis. When the cause is obscure and the degree of pyrexia slight, the fever is probably related to subinfection of the peritoneum by micro-organisms of low virulence. Chemical and cytological examination of the ascitic fluid and post-mortem examination of the peritoneum yield evidence that chronic peritonitis is common in cirrhosis of the liver.

MODERN METHODS OF TREATING FRACTURED FEMORA.

By W. ETHERINGTON WILSON,
Resident Medical Officer, 1st London General Hospital.

"To look back to Antiquity is one thing,
To go back to it is another."

(*Continued from p.* 107.)

PUTTING UP A FRACTURED FEMUR INTO THE FIRST POSITION (Fig. 1).

It is better to give a general anæsthetic; gas ought not to be used, and gas and oxygen in the hands of experts only. Complete relaxation is necessary.

The Thomas having been fitted, the leg and thigh are supported by four-inch-wide slings, clipped on the outer bar. The glue extension is applied, having first scrubbed the leg with a solution of sodium bicarbonate to get the grease out of the skin, thus enabling the glue to do its part better. The extension support is attached, the Sinclair foot-piece applied, and the Thomas with the fractured limb slung from the frame. As a routine, the bars of the splint should be bent slightly at the knee so that the latter lies flexed in the Thomas.

The nearer the fracture to the knee the more the splint is bent, and the further away the fracture from the knee the

straighter the splint. A middle-third fracture of the femur requires the knee flexed about ten degrees. The sling just above the knee and the one actually controlling the site of fracture are kept pulled up taut. If the leg now be pulled in this semiflexed position, leverage is obtained, enabling the lower fragment to be kept from sagging backwards. This backward sagging is one of the most common and serious disabilities resulting; more will be said about it later. It is necessary here to bear this in mind. The natural forward curve of the femur is aimed at, hence the sling at the site of the fracture is heaved up until the thigh presents this gentle curve forwards.

The ring of the Thomas is pulled up the thigh as far as anatomy will allow, and the extension is tied round the support. The foot of the bed is raised on the 12-in. blocks, the patient is brought well down the bed, and the end of the splint is tied with cord as near as possible to the vertical beam of the frame. The patient is only allowed one flat pillow, except at meal-times. The foot-piece is rotated so that the foot rests with the toes turned out in the walking position.

The patient is now "hanging by his leg," *i. e.* the body-weight is pulling on the cord; the cord is pulling the end of the splint, which causes the extension on the leg to pull the thigh. Thus the pull is obtained by body-weight, the amount depending on the slope of the bed.

Next day it may be found that the ring of the Thomas has been pulled downwards for an inch or more, this being due to the stretching of structures concerned in the pull. The cord and extension should be gently untied, the splint pulled up, and then the former tied again. The amount of pull going on can be gathered by feeling whether the cord tying the splint to the frame is taut or not. It must be kept pulled tight.

As regards discomfort, this only lasts two or three days, and is due to some extent to the patient's unusual position. Morphia gr. $\frac{1}{4}$ is given at once if there are any complaints of pain the first day. Patients soon get used to having their "legs pulled," and even like it—obviously so.

Pain is often due to spasm or traction on some particular muscle of the thigh; the adductors offend particularly Massage and morphia tide this over the first day or two.

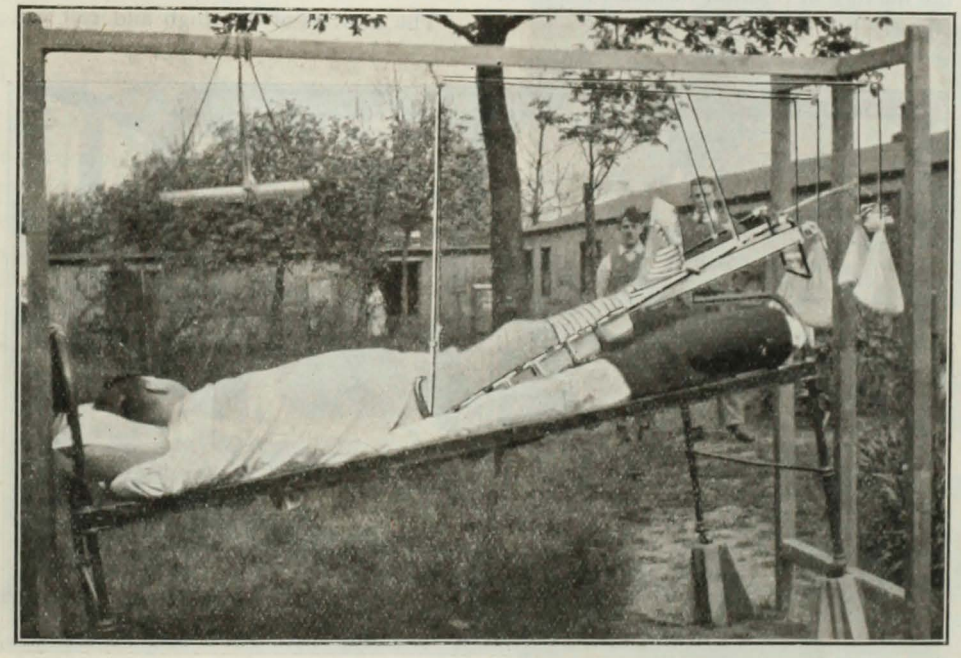


FIG. 1.—FIRST POSITION OF A FRACTURED FEMUR.

Skiagrams are taken two or three days after putting the case up: an anterior and a lateral view are necessary, except in upper third fractures, where lateral views are difficult to obtain. If the position is not satisfactory and adjusting of slings has to be done the skiagrams will need repeating to see the corrected position.

The first position lasts for eight weeks in an average simple fracture; the time, however, varies in some cases, and the following three points help to decide.

(A) *Amount of callus* and its quality shown in X-ray after 8 weeks. This varies very much in some cases.

(B) *Position of fractured ends.* — The following rough rules will be found useful as a guide:

(i) Perfect end-to-end apposition with visible and palpable callus around site of fracture: 9 *weeks.*

(ii) End-to-end junction with good, visible and easily palpable callus, when the fractured surfaces are only partially apposed: 8 *weeks*.

(iii) Cases with side-to-side apposition, *i. e.* with overlap and union with visible palpable callus: 10 *weeks*.

(c) The patient can raise the whole thigh in one piece quite painlessly, and he will say it feels very firm.

To recapitulate. The objects of the first position in femur treatment are:

(i) To obtain correct alignment of the fragments.

(ii) To keep the corrected position until the callus formed is sufficient in amount and quality to hold the fracture in position without the pull of the body-weight.

(iii) To prevent mal-union, causing disabilities.

(iv) To prevent shortening.

Obviously, then, the first stage in the treatment is the most important, because on it depends the result to be obtained.

Massage and Electrical Treatment.

Massage of the knee and patella, the quadriceps extensor muscles and the site of fracture should be commenced about six weeks after the fracture.

Electrical stimulation of the quadriceps by the Faradic current should be done for fifteen minutes daily, beginning after three weeks in the favourable cases.

The objects of massage and stimulation are to stimulate the formation of callus, to prevent muscular wasting, to prevent adhesions, especially about the patella and knee, resulting in stiffness of the joint.

SECOND POSITION (Fig. 2).

The extension cord tying the splint to the frame is removed; the foot of the bed is lowered by removing the blocks; the bars of the Thomas are straightened with irons, or if these are not available the splint should be changed for a straight Thomas. It is necessary to have the knee fully extended now to prepare for the third position of walking. The foot-piece is removed and the foot supported at right angles by a sling across the sole clipped in position between two uprights.

The limb now lies passively in the splint, being held there by the glue extension in the ordinary way; the extension by body-weight has done its work.

The muscles of the thigh and calf can now be brought into action and the foot can be moved as desired by the patient—in other words, a certain amount of stress is thrown on the site of fracture, and this is a most important factor in the hardening of callus. This stage, then, is one of passive hardening. The position described above is maintained for about seven days and then a knee-flexing arm is added to the apparatus (Fig. 2). The flexing-piece resembles the lower half of a Thomas splint, being less wide so as to fit inside the bars of the latter, to which it is attached by two screws $\frac{3}{4}$ in. above the line of the joint. The leg is transferred to this flexing splint, and by means of a pulley, etc., the patient is able to flex and extend his own knee by pulling a cord (see Fig. 2). The ends of the splints are tied by a long piece of tape limiting the range of flexion. The range of movement of the knee can be daily increased by letting out the tape as far as the patient will allow. When exercising

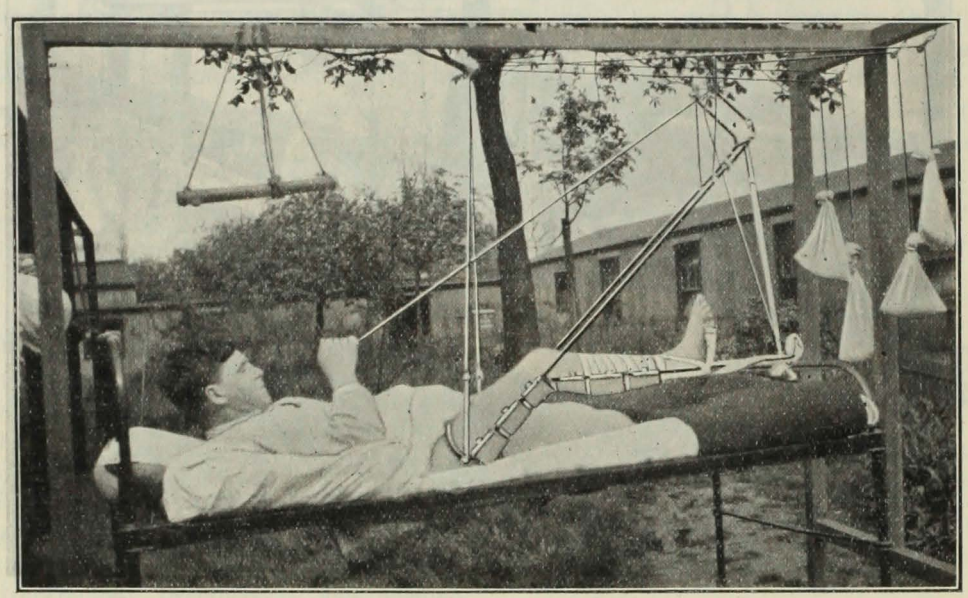


FIG. 2.—SECOND POSITION OF A FRACTURED FEMUR WITH KNEE-FLEXING PIECE.

the joint the leg should always be pulled up into the completely extended position.

Early movement of the knee is very necessary and the result in simple fractures is very good. In compound fractures of the femur, especially where septic processes are still at work among the muscles, resulting in adhesions and scarring, the early movement of the knee is unavoidably delayed.

The second position, including the flexing splint, is maintained for three to four weeks, but this again depends on the progress of the case.

To repeat once again : The second stage in the treatment of a fractured femur is a process of passive hardening of the flexible callus formed in the first stage, and is preparatory to the third stage of active hardening.

THIRD POSITION (Fig. 3).

All apparatus is removed, the limb is measured for a walking caliper, and while the latter is being made the leg lies in bed between sandbags, a pad being placed under the site of fracture.

Method of fitting a walking caliper.—An ordinary Thomas splint with a smaller sized ring is tried on the thigh. The ring is pulled and eased up the thigh as high up as anatomy will allow and must fit the thigh accurately in this position, so that no gap exists between it and the skin. The posterior and inner part of the ring must abut against the tuber ischii when the splint is pushed upwards ; it is most important that the tuberosity should not slip through the ring, as the whole idea is that when upright the patient should sit on the ring of the caliper.

The splint is now jammed up against the ischial tuberosity and the length of the limb recorded on the inner bar at the level of the sole of the foot at right angles, a scratch with a file being made. Another mark is made ¾ in. below the former. The splint is then sent to be made into a caliper, with instructions that the bend is to be made beyond the second mark, the cut horizontal ends fitting into a hole made on each side of the heel of the boot, the outer hole being placed about 1 in. further forward on the heel than the inner one. The object of this oblique fixation of the ends of the caliper is to keep the foot turned slightly outwards, as in walking. It will be seen now that when the walking caliper is worn it is too long for the patient, so that his heel does not touch the bottom of his boot by ¾ in. Thus the patient "sits" on his caliper when walking, and only a very small portion of the body-weight is thrown on the fracture through walking on the ball of the foot.

It is emphasised that the heel should not reach the bottom of the boot when walking ; disregard of this point may lead to bending of the fracture, with deformity and shortening.

It is necessary to support the knee in the caliper and to this end a trough splint is used, which can be moulded to fit the back of the limb accurately from the upper part of the thigh to the top of the boot. This is bandaged on, the same bandage also taking in the bars of the caliper from top to bottom, making the splint and leg secure and preventing the ends of the caliper from springing out of the boot when walking.

Correction of shortening and lengthening.—In the proper treatment of a fracture of the femur obtained within a week of the smash, it is just as easy to finish up with the limb a quarter of an inch too long as it is a quarter of an inch too short. The tendency of over-pulling with consequent lengthening has to be guarded against.

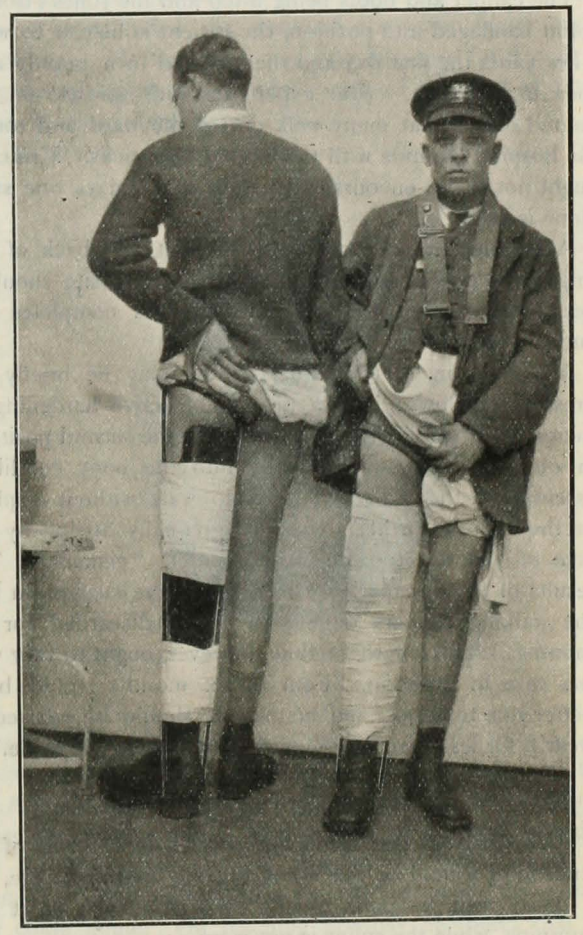


FIG. 3.—THIRD POSITION WITH THE WALKING CALIPER.

Each limb is measured from the anterior superior iliac spine to the tip of the internal malleolus, the patient lying quite square in the bed with legs outstretched. The same points are chosen on these bony landmarks, otherwise it is quite easy to make a mistake of an inch. Another less accurate measurement is from the anterior superior iliac spine to the upper border of the patella.

(*a*) If both limbs are of *equal length* add $\frac{3}{4}$ in. thickness to the heel of the sound boot (because the caliper on the other leg is $\frac{3}{4}$ in. too long), and $\frac{3}{8}$ in. bars (like football boots) to the sole.

(*b*) If the injured limb is, say, $\frac{1}{2}$ in. *short*, then the sound side must be raised $\frac{1}{4}$ in. ($\frac{3}{4}-\frac{1}{2}$) to make the lengths equal.

(*c*) If the injured limb is $\frac{1}{2}$ in. too *long*, then the sound side must be raised $1\frac{1}{4}$ in. ($\frac{3}{4}+\frac{1}{2}$).

Only half the difference in length is required to be put on the sole of the boot in these cases.

The caliper and boots being fitted and the Jones's trough splint bandaged into position, the patient is helped to walk a few yards the first day and then treated to a brandy and soda if necessary. Our experience with soldiers on the second day is that many walk out of the ward and round the hospital grounds with the help of two sticks. Crutches ought not to be encouraged. After a few days one stick alone is used.

A webbing strap attached to the front and back of the ring of the caliper and passing over the opposite shoulder keeps the ring up in the crutch and this completes the outfit.

The meaning of the third position may be briefly expressed as follows: It is a process of active hardening of the callus already partially prepared by the second position, in order to bring it gradually into the bony condition essential to the patient if he is to walk without a splint, or the fear of further deformity gradually arising by the give of the not too well consolidated "cement." The results of recent experience have led to the suggestion that the walking calipers ought not to be discarded for six months. The length of time, however, ought to vary with the case in question. Four to six months would be a better rule to adopt, and no patient should be advised to wear it for less than four months to be on the safe side.

FURTHER TREATMENT.

Daily massage and active and passive movements of the knee-joint should be carried out during the third stage.

Much can be done by the patient himself, night and morning, while the splint is not worn.

Great care is necessary during passive movements of the knee lest bending occur at the site of the fracture. This is particularly liable to occur in fractures of the lower third of the femur adjacent to the joint, in which cases vigorous methods will result in backward bending at the site of fracture.

In obstinate knee-joints following compound fractures a larger range of movement will be obtained when the patient is able to throw away his caliper and begin to use the knee by walking.

A STATE MEDICAL SERVICE.

REPORTS AND RETURNS.

By A CAPTAIN IN THE R.A.M.C.

THE following is an example of what much of the work consists of in a State Medical Service:

Reports and Returns. 2626/29(D.M.S.5).

ARMY HEADQUARTERS, INDIA,
MEDICAL BRANCH,
SIMLA;
October 19th, 1918.

From
THE DIRECTOR, MEDICAL SERVICES IN INDIA,

To
THE MEDICAL OFFICER
IN CHARGE OF PRISONERS OF WAR CAMP,
HOSPITAL, ——.

Memorandum.

With reference to the monthly return of sick for Turkish Prisoners of War for September, 1918, it is pointed out that the causes of deaths shown marginaliy is not considered sufficiently explanatory for statistical purposes.

Attention is invited to this Office letter No. 17243–15 (D.M.S.5) dated the 26th February, 1918.

(Signed) ——,
Lieut.-Colonel, R.A.M.C.
For Director of Medical Services in India.

Reply.

No. ——, Civilian, ——. Drowning (accidental).

Kindly note that this death should be returned as No. 1030 (*a*) Suffocation from submersion.

Kindly correct your office copy accordingly.

THE PAST AND PRESENT CRICKET MATCH.

By ONE OF THE "OLD 'UNS."

WHAT a pity it is that the "old 'uns" cannot both bat and field in the afternoon. We batted as usual after lunch, walked to the wickets 'midst sympathetic murmurs and encouraging glances from the bright eyes of our feminine admirers—and we rejoined them very shortly to explain what we would have done with that

bowling in the olden days and how we got out to the only good ball of the match. It is true that a surgeon, who was called away in the nick of time immediately previous to his going in, has emphatically declared that the bowling was poor and that he would probably have made a century. The fact remains, however, that the others did not often succeed in hitting the ball where they wished it to go.

On the other hand, our fielding was really admirable considering. Our wicket-keeper was in great form, a distinguished anæsthetist bowled a wicket to his evident surprise and delight, the aforesaid surgeon caught a catch in the slips 'midst the plaudits and congratulations of his colleagues, a neurologist of renown bowled three overs, and, being rather an expensive physician, was then removed from his office, and the team as a whole placed itself with great bravery directly in the way of the ball and dashed to the boundary—*after* the ball—time and again, oblivious of the fact that they would bitterly regret their unusual agility on the morrow. Altogether we felt quite pleased with ourselves, but this was all unseen by those whom we desired to impress.

Anyhow, we had an excellent lunch and tea, a delightful day, and a few hours in which to renew old friendships. Also we hope to be asked to play again next year. We were not downhearted, though some of us were stiff and sore for days afterwards.

PRESENT.		PAST.	
S. Orchard, b Dalton	12	S. G. Etheridge, c Parkes, b Parrish	6
J. Parrish, c Last, b Dalton	5	H. M. Williams, run out	12
A. E. Parkes, c and b Dalton	68	C. M. Hinds Howell, b Parrish	6
P. C. Collyns, c Gibson, b Etheridge	18	C. W. O'Brien, st Bracewell, b McCall	2
C. H. Bracewell, c Gibson, b Last	34	H. A. Dalton, not out	23
H. D. McCall, b Dalton	15	H. E. S. Boyle, b Parrish	11
M. G. Thomas, not out	33	L. B. Rawling, absent	0
R. S. Coldrey, c Rawling, b Dalton	4	H. J. Churchill, b McCall	1
H. V. Morlock, st Gibson, b Dalton	0	F. H. Robbins, c and b Parrish	7
T. E. Moody-Jones, b Etheridge	15	R. W. B. Gibson, b Parrish Last, b McCall	1 0
S. Mahmoud, b Boyle	0		
Extras	27	Extras	4
Total	231	Total	73

OBITUARY

ARTHUR CARLILE STURDY, M.C., F.R.C.S.

CAPTAIN Arthur Carlile Sturdy, M.C., F.R.C.S., died of dysentery in the Colaba Military Hospital, Bombay, on May 1st, at the age of 36. He was the second son of the Rev. H. C. Sturdy, formerly Vicar of St. Paul's, Dorking. He was educated at St. Paul's School, whence he went to Cambridge and afterwards to St. Bart.'s, where he held the posts of House-Surgeon and Intern Midwifery Assistant. After leaving the Hospital he became Senior Resident Medical Officer at the Royal Free Hospital. For a time he was practising at Baldock, and in 1913 he entered into partnership with Messrs. Vernon, Kinneir, Juckes, Stevens & Jamison at Horsham. He became a member of the staff of the Horsham Cottage Hospital, and in that capacity did a considerable amount of surgical work.

Early in the summer of 1915 he volunteered for service in the R.A.M.C., and served in France until June, 1917. During the latter part of this time he was attached as M.O. to the 2nd Hampshires, and while with that regiment he gained the Military Cross. The official account says that "he attended the wounded for many hours under heavy fire. He showed a complete disregard for danger in organising search parties, and recovered wounded who had been left for several days."

He returned home in June, 1917, after completing two

THE LATE CAPT. ARTHUR CARLILE STURDY.

years' service with the rank of captain. On the demand for more medical officers in October, 1917, he rejoined the R.A.M.C., and was soon sent to Mesopotamia, serving in a casualty clearing station, and latterly as Surgeon-Specialist in the 33rd Base General Hospital in Basra, where he remained until April of the present year, when he started to come home. On reaching Bombay he found that he could not get a ship for some weeks, and went to Naini Tal to see a brother who was suffering from dysentery. In Naini Tal Captain Sturdy himself suffered from dysentery, and was admitted into hospital; after a short stay there he appeared to have quite recovered, and returned to Bombay, expecting to embark for home. On the journey by rail he had a recurrence of his illness, and was removed from Bombay station in an ambulance to the Colaba Hospital, where he died the following night. His unexpected death after three and a-half years of hard and faithful service comes as a very hard blow to his many friends, who have been eagerly hoping to welcome him home. He knew his

work well, and always did it thoroughly. As a colleague he was always reliable in all things, and he knew how to gain the confidence and affection of his patients. Those who knew him best liked and respected him most. Though his place knows him no more, his memory will live with his friends of all classes. He had a charming personality, and he worked hard without stint and without jealousy. His professional attainments were high, and he was ever eager to learn. He seemed to have a bright future. He was a keen lover of music and an enthusiastic mountaineer.

St. Bart.'s has lost a devoted son of whom she may be proud. May he rest in peace. M. H. H. V.

ABERNETHIAN SOCIETY.

AT a meeting of the Abernethian Society held on Thursday, May 15th, Dr. Alex Macphail, Lecturer on Anatomy, introduced a discussion on the need for reform in the provision of anatomical material for medical schools. Dr. Macphail first briefly reviewed the history of anatomy and the difficulties and crimes which led to the passing of the Anatomy Act in 1834—an aspect of the subject on which two previous addresses of his to the Society have already been published in the JOURNAL in recent years. He then explained how the purpose of the Act had been frustrated in many ways, ways unforeseen by the enlightened politicians who passed it into law in the full belief that it would provide all the anatomical material required by the schools for all time. Dr. Macphail, from his position as Secretary of an International Committee of Licensed Teachers of Anatomy and Operative Surgery, was able to say something of the steps which had been taken to get the present Government to deal with the problem on lines suited to the needs of the present time, and was hopeful that a marked improvement in the supply might be attained in the near future. But he pointed out that the "subjects" on which teaching and research in anatomy and operative surgery are dependent, the bodies of the unclaimed dead, are becoming a vanishing quantity owing to the steadily increasing success of many measures which are tending to reduce the ranks of pauperism in this country. Thus the time must soon come, in no very distant future, he said, when other means of providing "subjects" must be found if the only sure foundation of medicine and surgery is to be secured, viz. the dissection of and operative practice on the the dead. The lecturer dwelt on the possibility of history having to repeat itself through medical students being forced through lack of human subjects to learn anatomy solely by dissecting lower animals; but this would mean a return to the dark ages of medical study, and the problem must be solved, if possible, in other ways. Pointing out to the younger members of the Society that the problem will be theirs to solve, Dr. Macphail advocated frank dealing with the public, rich and poor alike, in whose best interest it is, in the long run, that the practitioners to whom they entrust their health in life should be adequately provided with the necessary training in anatomy and operative surgery during their student career.

At Dr. Macphail's suggestion a discussion was then opened by the President, Mr. Fisher, in which various members took part, and several important points were raised and considered.

The vote of thanks proposed by the Secretary, Mr. Zerolo, was seconded by Mr. Hume, both of whom referred to the great interest and initiative taken by Dr. Macphail in a matter of such vital importance to the medical profession. The vote was carried with acclamation.

T. F. ZEROLO
N. S. B. VINTER } *Hon. Secs.*

RAHERE LODGE.

THE Installation Meeting of the Rahere Lodge, No. 2546, was held in the Great Hall of St. Bartholomew's Hospital on Tuesday, June 17th, 1919. Three candidates, G. W. Stone, W. B. Heywood-Waddington, and C. H. Thomas, were initiated by the W.M., W.Bro. Hepburn. W.Bro. Ernest Clarke delivered the charge to the Initiates. W.Bro. Hepburn then installed W.Bro. Swinford Edwards as Worshipful Master for the ensuing year. The charges were delivered by W.Bro. Hepburn, W.Bro. Laming Evans and W.Bro. Perram. The following officers were appointed:

W.Bro. F. SWINFORD EDWARDS	W.M.
W.Bro. A. HEPBURN	I.P.M.
Bro. E. W. BREWERTON	S.W.
Bro. H. PRITCHARD	J.W.
Bro. The Rev. DAND	Chaplain.
W.Bro. ERNEST CLARKE, P.M., P.G.D.	Treasurer.
W.Bro. E. LAMING EVANS, P.M., L.R.	Secretary.
W.Bro. M. L. TRECHMAN, P.M., L.R.	D.C.
Bro. A. S. WOODWARK	S.D.
Bro. GIRLING BALL	J.D.
W.Bro. H. MORLEY FLETCHER, P.M., P.G.D.	1st Asst. D.C.
W.Bro. FRANCIS CLARK, P.G.D.	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. R. M. VICK	Asst. Secretary.
W.Bro. G. H. WHITAKER, L.R.	I.G.
W.Bro. E. P. FURBER, P.P.G.J.W., Surrey	Sen. Steward.
Bro. J. CUNNING	Steward.
Bro. F. A. ROSE.	Steward.
W.Bro. A. H. COUGHTREY	Tyler.
Bro. E. W. HALLETT	Asst. Tyler.

After the ceremony in the Great Hall, seventy-seven members and guests met at the banquet at the Imperial Restaurant. Many brethren resumed their masonic duties after a lapse of five years. The evening was marked at an

early stage by a spontaneous outburst of joyous congratulation to the Father of the Lodge, W.Bro. Sir D'Arcy Power, upon the recent honour of Knight Commander of the Most Excellent Order of the British Empire conferred upon him. Wild enthusiasm was followed by the singing of "He's a jolly good fellow."

The Sheriff of the City of London, W.Bro. Banister Fletcher, responded to the toast of the "Grand Officers," and W.Bro. Sir John Cockburn, K.C.M.G., himself a medical man, and latterly Agent-General for South Australia, responded for the visitors.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

AT the Annual General Meeting held in March for the election of officers, the following were elected:

Captain 1st XV	C. Shaw.
Vice-Captain	M. G. Thomas.
Secretary	S. Orchard.
Captain 2nd XV	N. G. Thomson.
Secretary	E. F. Peck.
Captain 3rd XV Secretary	Not elected.

Full fixture lists for three XV's have been arranged. The 1st XV fixtures include matches with Harlequins, Richmond, Roslyn Park, London Welsh, London Irish, Oxford University, Cambridge University, United Services Portsmouth, Rugby, Coventry, and all the "Old Boys'" teams.

University College Hospital will be met in the 1st Round of the Hospital Cup.

CRICKET CLUB.

Up to the present the Hospital have only won two matches. We have been unlucky in not being able to put our whole strength into the field for the majority of matches, the absence of Melle and McCall especially being severely felt. The batting has been disappointing, chiefly owing to lack of nets. Most of the runs have come from the first three or four. Against the Cryptics, however, we gave our best batting display of the season, everybody batting well to make a creditable draw. We have had a good number of runs scored against us. The bowlers have had no assistance from the wickets, but too many loose balls are sent down, and no one can be relied on to keep a good length. The ground fielding has been good, and the catching moderate.

v. WINCHMORE HILL. *Lost.*

Winchmore Hill, 136. Bart.'s, 125 (Melle, 56).

v. SOUTHGATE. *Lost.*

Southgate, 144. Bart.'s, 98 (Melle, 26).

v. HORNSEY. *Drawn.*

Bart.'s, 233 (Melle, 109; Orchard, 73; Parkes, 33 not out). Hornsey, 230 for 6 wickets.

v. OLD CITIZENS. *Won.*

Old Citizens, 27 (Melle, 6 for 9; McCall, 4 for 14). Bart.'s, 294 (McCall, 61; Melle, 50; Orchard, 57).

v. GUY'S (1ST ROUND, CUP). *Lost.*

Bart.'s, 187 (Melle, 92). Guy's, 232.

v. WELLINGBORO' MASTERS. *Lost.*

Wellingboro', 336 for 4; declared. Bart.'s, 128 (Parkes, 38, Bracewell, 24).

v. Dr. CALVERT'S XI. *Lost.*

Dr. Calvert's XI, 139. Bart.'s, 129 (Bracewell, 36; Orchard, 34).

v. R.A.M.C., ALDERSHOT. *Lost.*

R.A.M.C., 209. Bart.'s, 127 (Parkes, 52; Orchard, 30).

v. PAST. *Won.*

Present, 231. Past, 73.

v. CRYPTICS. *Drawn.*

Cryptics, 311 for 8, declared. Bart.'s, 191 for 6 (Bracewell, 69 not out; Orchard, 33).

v. ALEXANDRA PARK. *Lost.*

Bart.'s, 180 for 6, declared (Orchard, 67; Bracewell, 29). Alexandra Park, 181 for 6.

v. INDIAN GYMKHANA. *Lost.*

Indian Gymkhana, 301 for 8, declared. Bart.'s, 84 (E. Coldy, 32).

v. CHESHUNT. *Lost.*

Bart.'s, 139 (Parkes, 53). Cheshunt, 140 for 4.

LAWN TENNIS CLUB.

Great difficulty has been experienced this year in discovering the best talent in the Hospital as no lawn tennis to speak of has been played during the war; but by the inauguration of a Hospital tournament, and thanks to the energies of Messrs. J. G. Johnstone and H. T. Hendley, it was possible to select a representative team to play against Guy's Hospital on June 13th in the First Round of the Inter-Hospital Cup Tie.

Of the four matches played so far the Hospital has won three and lost one, viz. against Chiswick Park "B." Krige and Johnstone did well to win all their three matches against Chiswick "B."

The match against the Gentlemen of Winchmore Hill proved an easy win for the Hospital, the first and second pairs experiencing no difficulty in winning all three of their matches.

The match against the Past on June 11th was played under ideal conditions. The Past were obviously out of practice, showing great knowledge of the game, but not bringing off their strokes with precision till the end of the afternoon, when it was evident that the Present would have had their work cut out to win had the Past been in form at the first.

The First Round of the Inter-Hospital Cup Tie against Guy's Hospital saw the Hospital at its full strength for the first time, and resulted in a win for Bart.'s by eleven matches to three. St. Bartholomew's won five Singles out of the six, despite their lack of practice in Singles, so it was only necessary for them to win three of the "Doubles" matches in the afternoon to win. This they soon did, the first two pairs of the Hospital again winning all three matches.

RESULTS.

St. Bartholomew's Hospital *v.* Chiswick Park "B" was played at Winchmore Hill on June 4th, 1919, the result being a win for the visitors by 5 matches to 4.

St. Bartholomew's Hospital *v.* Gentlemen of Winchmore Hill, June 7th, 1919, at Winchmore Hill, resulted in a win for the Hospital by 7 matches to 2 and 106 to 62 games.

The Present *v.* the Past—played at Winchmore Hill June 11th, 1919—resulted in a win for the Present by 7 matches to 2 and 107 games to 68.

St. Bartholomew's Hospital *v.* Guy's Hospital (Inter-Hospital Cup Tie), played at Winchmore Hill on June 13th, 1919, resulted in a win for St. Bartholomew's Hospital by 11 matches to 3 and 183 games to 131.

CORRESPONDENCE.

THE TREATMENT OF AMŒBIC DYSENTERY.

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

SIR,—In recent issues of the JOURNAL I have read with interest Capt. Prall's paper and Major Maxwell's letter on the treatment of amœbic dysentery.

Capt. Prall did not have his cases long enough under observation to know if his treatment had really brought about cure.

It is true, as Major Maxwell writes, that heroic doses of ipecacuanha are no longer necessary. It was always a difficult—to put it mildly—form of treatment. Natives of India "put up with it" more readily than Europeans. However, it was often completely effective, as careful microscopic investigation of stools over lengthy periods, following on treatment, showed.

A lively memory of that form of treatment, both as administrator—of necessity forceful if not bullying—and, in due turn, revolting patient and receiver, compels agreement with Major Maxwell that, with emetine at hand, it is a barbarous treatment. In quite small doses, however, ipecacuanha is still useful and effective in certain cases.

The "cure" of carrier cases by bismuth emetine iodide is probably just as satisfactory as Major Maxwell claims; it is not wise, perhaps, yet to make any too definite statements about the permanency of these cures. However this may be, all experience of the disease to-day leaves no doubt at all that the B.E.I. treatment of chronic cases and carriers is a great improvement on the method of hypodermic injection of emetine hydrochloride by itself.

While not daring the attempt to define "excessive" or "too long" in relation to the use of emetine and/or bismuth emetine iodide, I may be allowed to state that, like Major Maxwell, I have never been able to convict emetine or B.E.I. of any ill-effects following its use. Consideration is due to the facts that—

(1) Some cases of chronic amœbic dysentery undergoing emetine and/or B.E.I. treatment show D.A.H.

(2) Some cases after apparent cure of dysentery by one or more courses of emetine and/or B.E.I. show D.A.H.

(3) Some cases of D.A.H.—their only objective or subjective symptom—are found to be infected with *Entamœba histolytica*.

In all these cases (1, 2, 3) *E. histolytica* can be demonstrated.

In most of these cases (1, 2, 3) D.A.H. disappears after *E. histolytica* disappears.

In most of the cases (3) *E. histolytica* disappears on treatment with B.E.I. or B.E.I. and emetine hydrochloride combined.

There is surely excuse for the proposition that the D.A.H. in emetine hydrochloride and/or B.E.I. treated amœbiasis may be caused by the entamœbæ and not by the emetine.

I am, Sir,
Yours faithfully,
H. M. HANSCHELL.

LONDON SCHOOL OF TROPICAL MEDICINE
(UNIVERSITY OF LONDON),
ROYAL ALBERT DOCK, E.;
June 10th, 1919.

EXAMINATIONS, ETC.

UNIVERSITY OF LONDON.

Third (M.B.B.S.) Examination for Medical Degrees, May, 1919.

Honours.—R. J. Perkins, Distinguished in Medicine, Forensic Medicine and Surgery. University Medal.

Pass.—J. E. A. Boucaud, J. Capell, P. Selwyn Clarke, G. F. Cooke, J. N. Leitch, B. H. Pidcock.

Supplementary Pass List, May, 1919.

Group I.—R. G. Lyster, C. H. Thomas, W. R. White-Cooper.

CHANGES OF ADDRESS.

ANDREW, JOHN, 5*a*, Penywern Road, Earl's Court, S.W. 5.
DALLY, J. F. HALLS, 93, Harley Street, W. 1. (Tel. Mayfair 2697, unchanged.)
DRAKE, E. C., 23, Park Square, Regent's Park, N.W. 1 (After July 12th.)
FIDDIAN, J. V., 76, Dunham Terrace, Ashton-under-Lyne.
HOWELL, B. W., 35, Weymouth Street, W. 1; and 55, Cornwall Gardens, S.W. 7. (Tels. Western 4141 and 361.)
JOHNSON, H. J., Heathgate Corner, N.W. 4.
KING, H. H., Capt. I.M.S., c/o Cox & Co., Bombay.
MILNER, S. W., Caprera, Cleveland Road, Torquay.
PAYNE, J. E., 57, Carlisle Road, Eastbourne.
PRANCE, C. H. G., Ashtead, Surrey.
QUICK, H. E., 137, Walter Road, Swansea.
ROBERTS, J. E. H., (Residence) 1*k*, Montagu Mansions, Portman Square, W. 1. (Tel. Mayfair 4818.)
ROBERTSON, J. F., Ullesthorpe Grange, near Lutterworth.
SMITH, N. F., 6, Queen's Road, Hertford.
WALLER, H. M., Oakfield, Ellesmere Port.
WARD, R. OZIER, St. Peter's Hospital, Henrietta Street, W.C. 2.
WRANGHAM, J. M., Stones House, Ripponden, near Halifax.
YOUNG, F. P., Dilkhusha, Newquay, Cornwall.

APPOINTMENTS.

BOURNE, GEOFFREY, M.B., B.S.(Lond.), M.R.C.P., appointed Assistant Physician to the Queen's Hospital for Children.
RIVIERE, B. B., F.R.C.S., appointed Honorary Surgeon to the Jenny Lind Children's Hospital, Norwich.
SCOTT, W. H., M.R.C.S., L.R.C.P., appointed Resident Medical Officer at the Western Dispensary, Rochester Row.
SHAH, J. M., Capt. I.M.S., M.R.C.S., L.R.C.P., appointed M.O. i/c Troops and O.C. Military Detention Hospital, Jaffa, Palestine, E.E.F.
SMITH, N. F., M.R.C.S., L.R.C.P., appointed Assistant Honorary Medical Officer to the County Hospital, Hertford.
WARD, R. OZIER, D.S.O., M.C., F.R.C.S., appointed Junior House-Surgeon to St. Peter's Hospital, London.

BIRTHS.

BLAKEWAY—On June 29th, at the Cottage, Poplar Grove, Woking, the wife of the late Harry Blakeway, F.R.C.S., of a daughter.
RIVIERE.—On January 5th, 1919, at St. Giles Plain, Norwich, to Veronica, wife of Bernard B. Riviere, F.R.C.S.(Eng.)—a son.
SCHOLTZ.—On May 4th, at Secunderabad, India, the wife of Capt. Claude J. Scholtz, R.A.M.C., of a son.
WALKER.—On June 1st, at St. John's Wood, the wife of L. A. Walker, M.D., Capt., R.A.F., of 37, Piccadilly—a son.

MARRIAGES.

ACKLAND—MARLOW.—On May 18th, 1919, at St. Dionis Church, Kensington, by the Rev. Dr. Carter, J. G. Ackland, Capt., R.A.M.C., to Dorothy, daughter of Mrs. Marlow, of Arundell Mansions, Kensington, W.
GRAY—FULLER.—On May 28th, at Fletton Parish Church, Peterborough, Frank Gray, M.B., B.Ch., B.A.(Cantab.), Surg.-Lieut., R.N., to Mary, eldest daughter of the late Mr. G. Fuller and of Mrs. Fuller, of Peterborough.
HINE—LILLYWHITE.—On June 4th, at St. Gabriel's, Warwick Square, by the Rev. Cecil Image, cousin of the bride, T. G. Macaulay Hine, M.D., Major, R.A.M.C., to Margaret Ellen, only daughter of Mr. and Mrs. Herbert Lillywhite, of Broadfield, Guildford.

DEATHS.

CARTWRIGHT.—On June 23rd, 1919, at Oswestry, John Peploe Cartwright, M.R.C.S.(Eng.), aged 70.
EARLE.—On June 5th, 1919, at his residence, East Hayes House, Bath, Walter George Earle, M.R.C.S., L.R.C.P., aged 64.
MACMILLAN.—On May 23rd, 1919, at the Military Hospital, York, Edgar Duncan Macmillan, M.R.C.S., L.R.C.P., only son of Major J. M. Macmillan, R.A.M.C., York, and dearly loved *fiancé* of Miss Millicent H. Burton, Walton, Stafford, aged 24.
WAY.—On June 14th, at Chale, Isle of Wight, Gladys Elizabeth Mary, the beloved wife of Capt. Leslie F. K. Way, D.S.O., R.A.M.C.

NOTICE.

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

St. Bartholomew's Hospital Journal.

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

VOL. XXVI.—NO. 11.] AUGUST 1ST, 1919. [PRICE SIXPENCE.

CALENDAR.

Tues., July 29.—Dr. Drysdale and Sir Anthony Bowlby on duty.
Fri., Aug. 1.—Dr. Tooth and Sir D'Arcy Power on duty.
Tues., ,, 5.—Sir Archibald Garrod and Mr. Waring on duty.
Fri., ,, 8.—Dr. Calvert and Mr. McAdam Eccles on duty.
Tues., ,, 12.—Dr. Fletcher and Mr. Gask on duty.
Fri., ,, 15.—Dr. Drysdale and Sir Anthony Bowlby on duty.
Tues., ,, 19.—Dr. Tooth and Sir D'Arcy Power on duty.
Fri., ,, 22.—Sir Archibald Garrod and Mr. Waring on duty.
Tues., ,, 26.—Dr. Calvert and Mr. McAdam Eccles on duty.
Fri., ,, 29.—Dr. Fletcher and Mr. Gask on duty.
Tues., Sept. 2.—Dr. Drysdale and Sir Anthony Bowlby on duty.

EDITORIAL NOTES.

IN addition to the list of the members of our Staff who were included in the Birthday Honours, it gives us very great pleasure to publish the names of so many other Bart.'s men who were similarly honoured, and to one and all we offer our warmest congratulations.

C.B.—Lieut.-Col. (Act.-Col.) R. Pickard.

Knight Bachelor.—J. C. Verco.

K.B.E. (*Military Division*).—Surg.-Capt. A. S. Nance, R.N.

C.B.E.—Lieut.-Col. (Temp. Col.) H. G. Barling, Lieut.-Col. and Brevet-Col. L. K. Harrison, Temp. Maj. (Temp. Lieut.-Col.) W. de M. Hill, Maj.-Gen. O. R. A. Julian, Lieut.-Col. and Brevet-Col. C. W. M. Moullin, Temp. Col. J. H. Parsons, Lieut.-Col. L. W. Rolleston, Lieut.-Col. (Temp. Col.) A. S. Woodwark, Col. F. W. Begbie, Temp. Maj. and Act.-Lieut.-Col. W. P. S. Branson, Capt. (Temp. Col.) H. Burrows, Temp. Capt. (Act.-Lieut.-Col.) F. Fraser, Lieut.-Col. E. C. Hayes, Col. H. S. Thurston, Capt. (Temp. Maj.) A. S. Cane, Capt. T. S. Hele.

O.B.E.—Capt. (Act.-Maj.) A. Abrahams, Lieut.-Col. H. A. Berryman, Maj. R. H. Bremridge, Maj. M. A. Cooke, Temp. Capt. P. W. Dove, Capt. and Brevet-Maj. A. G. R. Foulerton, Temp. Hon. Maj. T. G. M. Hine, Maj. (Act.-Lieut.-Col.) E. B. Lathbury, Temp. Capt. E. G. D. Murray, Temp. Capt. W. A. Murray, Lieut.-Col. C. T. Parsons, Maj. W. G. Spencer, Lieut.-Col. R. M. West, Temp. Capt. E. D. Wortley, Temp. Lieut.-Col. W. Wrangham, Temp. Maj. W. P. Yetts, Maj. G. E. O. Fenwick, Maj. A. W. Izard, Capt. R. D. Parker, Maj. J. C. A. Rigby, Maj. A. H. Hogarth, Maj. J. Everedge, Capt. (Act.-Maj.) G. F. P. Gibbons, Temp. Capt. E. T. C. Milligan, Temp. Capt. R. F. Moore, Temp. Maj. M. W. B. Oliver, Temp. Capt. (Act.-Maj.) H. W. Scawin, Lieut.-Col. G. C. E. Simpson, Lieut.-Col. G. N. Stephen, Capt. (Act.-Maj.) L. R. Tosswill, Temp. Capt. (Act.-Maj.) M. Bates, Capt. (Act.-Maj.) M. J. Holgate, Capt. H. S. C. Starkey, Temp. Capt. (Act. Maj.) R. H. Strong, Maj. (Act.-Lieut.-Col.) J. J. Urwin, Maj. (Temp. Lieut.-Col. H. M. Cruddas, Lieut.-Col. F. E. Fremantle, Capt. J. C. John, Temp. Capt. C. R. Taylor.

M.B.E.—Capt. C. R. Woodruff, Capt. E. P. Carmody.

D.S.O.—Capt. (Act.-Lieut.-Col.) H. N. Burroughes, Lieut.-Col. A. D. Ducat, Capt. (Act.-Lieut.-Col.) I. R. Hudleston, Capt. (Act.-Lieut.-Col.) L. F. K. Way, Capt. (Act.-Maj.) R. O. Ward, Maj. and Brevet-Lieut.-Col. (Act.-Lieut.-Col.) H. M. H. Melhuish, Maj. (Act.-Lieut.-Col.) H. T. Samuel.

M.C.—Capt. G. H. H. Waylen.

To be Brevet-Colonel.—Lieut.-Col. (Temp. Col.) L. Humphry.

To be Brevet-Lieutenant-Colonel.—Maj. H. Skelding, Maj. M. G. Pearson, Maj. (Act.-Lieut.-Col.) F. P. Connor, Maj. (Act.-Lieut.-Col.) R. A. Lloyd.

To be Brevet-Major.—Capt. H. S. Dickson, Capt. R. A. Peters, Capt. E. S. Winter.

Croce de Guerra.—Temp. Capt. H. E. M. Baylis, Lieut.-Col. (Temp. Col.) R. Pickard, Capt. O. Teichman.

Order of the Rising Sun, Fourth Class.—Col. W. R. Smith.

Mentioned in Despatches.

Italy.—R.A.M.C.: Capt. (Act.-Lieut.-Col.) J. J. H. Beckton, Capt. W. Broughton-Alcock (S.R.), Temp. Capt. C. H. G. Prance, Capt. C. C. Robinson (T.F.). *A.M.S.:* Col. R. Pickard, C.M.G., T.D.; Temp. Col. C. G. Watson, C.M.G.

Egypt.—A.M.S. and *R.A.M.C.:* Lieut.-Col. (Temp. Col.) E. P. Sewell, C.M.G., D.S.O.; Temp. Capt. (Act.-Maj.) M. Bates, Temp. Capt. J. B. Binns, Temp. Capt. F. Brickwell, Capt. E. A. P. Brock, Capt. E. Catford, Temp. Capt. (Act.-Maj.) R. H. Strong. *R.A.M.C.T.:* Capt. (Act.-Lieut.-Col.) H. S. Beadles, Capt. M. T. G. Clegg, Capt. H. M. McC. Coombs, Maj. (Act.-Lieut.-Col.) H. T. Samuel, Capt. (Act.-Maj.) A. L. Sharpin, Capt. W. S. Soden, Capt. H. S. C. Starkey. *I.M.S.:* Capt. F. J. Anderson, M.C.; Capt. T. L. Bomford; Maj. and Brevet-Lieut.-Col. (Temp. Col.) G. Browse, D.S.O.; Capt. (Act.-Maj.) M. J. Holgate, Maj. and Brevet-Lieut.-Col. (Act.-Lieut.-Col.) H. M. H. Melhuish, Maj. (Act.-Lieut.-Col.) J. J. Urwin.

Salonika.—R.A.M.C.: Capt. (Act.-Maj.) A. S. Cane, Temp. Capt. H. H. L. Ellison, Temp. Capt. J. K. Willis. *R.A.M.C.T.:* Capt. T. S. Hele, Capt. (Act.-Maj.) H. A. Playfair-Robertson, Capt. (Act.-Maj.) R. M. Vick.

Mesopotamia.—R.A.M.C.: Temp. Capt. H. G. Baynes, Temp. Capt. C. R. Taylor, Capt. J. M. Weddell. *R.A.M.C.T.:* Lieut.-Col. F. E. Fremantle. *A.M.S.:* Temp. Col. T. P. Legg, C.M.G.; Col. A. H. Morris; Col. W. H. Starr, C.B., C.M.G. *I.M.S.:* Maj. (Act.-Lieut.-Col.) F. P. Connor, D.S.O.; Lieut.-Col. H. M. Cruddas, C.M.G.; Maj. and Brevet-Lieut.-Col. W. H. Hamilton, D.S.O.; Capt. J. C. John.

* * *

The following gentlemen have been nominated to House Appointments commencing August 1st, 1919:

House-Physicians—		
Dr. Tooth.	C. E. Kindersley.	Senior.
	H. A. Bell.	Junior.
Sir A. Garrod.	H. A. Douglas.	Senior.
	G. S. Trower.	Junior.
Dr. Calvert.	F. G. Lescher.	Senior.
	C. Herington.	Junior.
Dr. Fletcher.	M. V. Boucaud.	Senior.
	S. M. Cohen.	Junior.
Dr. Drysdale.	G. F. P. Gibbons.	Senior.
	E. I. Lloyd.	Junior.
House-Surgeons—		
Sir D'Arcy Power.	P. Kittel.	Senior.
	G. B. Richardson.	Junior.
Mr. Waring.	C. W. Bennett.	Senior.
	F. D. Marsh.	Junior.
Mr. Eccles.	G. A. Fisher.	Senior.
	C. Dunscombe.	Junior.
Mr. Rawling.	W. S. Sykes.	Senior.
	T. G. Evans.	Junior.
Mr. Gask.	R. M. Dannatt.	Senior.
	E. Coyte.	Junior.

These appointments are made for a period of three months. Juniors will automatically become Seniors at the end of the three-months' period.

House-Surgeon to Venereal and Skin Department	H. J. Levy.
Extern Midwifery Assistant	P. C. Collyns.

These appointments are for a period of three months.

* * *

At a meeting of the Council of the Royal College of Surgeons of England held on July 10th, Sir Anthony Bowlby was elected a Vice-President.

Sir D'Arcy Power was re-elected a member of the Executive Committee of the Imperial Cancer Research Fund.

* * *

We learn with much interest that Dr. A. R. Neligan has been appointed to the Persian Government Hospital with instructions to re-organise it on modern lines. Until recently the hospital was in German hands.

* * *

Sir George Newman, K.C.B., late lecturer on Public Health at this Hospital, has been appointed Chief Medical Officer of the newly formed Ministry of Health, with a position in the Government service which corresponds to that of the Secretary of a Ministry. By special arrangement Sir George also retains his position as Chief Medical Officer of the Board of Education.

* * *

We have received several letters from our readers requesting that a list of the times of attendance of physicians and surgeons at the various departments should be published at intervals. These times are still somewhat unsettled, but it is hoped by October to have the arrangements completed, and, in any case, we propose to publish in that issue as complete a list as possible.

* * *

With much regret we have to record the death of Dr. George Wilks, a well-known resident of Ashford. Born in 1840, he commenced his studies at Cambridge, taking his degree in the Classical Tripos in 1863, and subsequently studied at this Hospital, where he was a pupil of Sir James Paget. After qualifying he returned to Ashford and started in practice with his father in 1868. After the death of his father in 1878 Dr. Wilks carried on the practice alone until 1886, when he was joined in partnership by Mr. E. Colville, who still carries on the practice.

Dr. Wilks was well known amongst medical practitioners outside his native country, and in 1907 became Master of the Worshipful Society of Apothecaries. He was a prominent Freemason and for many years a county Justice of the Peace.

A SKETCH OF THE GROWTH OF THE SURGERY OF THE FRONT IN FRANCE.

An Address to the Abernethian Society of St. Bartholomew's Hospital.

By Sir Anthony Bowlby, K.C.B., K.C.M.G., K.C.V.O.,
Lately Consulting Surgeon, British Armies in France.

IT is about eighteen years since I addressed the Abernethian Society after my return from the South African War, where I had been in surgical charge of the "Portland Hospital."

I had at that time got to know much of the work of the Army Medical Service, and subsequently, as Consulting Surgeon to Millbank Military Hospital and in other ways, I had kept in touch with this branch of our profession. It was probably partly in consequence of this that, when the war was about a week old, I was offered by Sir Arthur Sloggett the appointment of Consulting Surgeon in France, and my friend Sir George Makins was also selected. I have never been able to learn why the B.E.F. did not require our services at once, but the fact is that it was past the middle of September before they allowed us to leave England, and it was the 23rd of that month before I sailed for Havre.

I lost no time in going to Paris, for it was there that the headquarters of the L. of C. was situated, and I was soon visiting various hospitals in or near that city. The Battle of the Aisne was drawing to a close, and our casualty clearing stations were engaged in field ambulance work and in entraining wounded. During the fighting at Mons, in the retreat, and at the Marne they had not been employed, and at the Aisne also most of their kit and stores were not being utilised. We had as yet no motor ambulance cars. Many of the wounded came into Paris, but most of them were being sent to Rouen, so after a few days I also went there, and spent my time in the two general hospitals which were at work.

Everything I saw pointed to great difficulties in dealing with the wounded at the front, and I was deeply impressed by the condition of the patients on their arrival at the base hospitals. It seemed to me that I might be of more use further forward than at Rouen, and this feeling was very much accentuated when I learnt that the British Army was leaving the Aisne and moving northwards. I therefore asked if I could not be of more service in that direction, and was much gratified to receive an order on October 12th telling me to report at general headquarters. I lost no time in obeying, and left early next morning for Abbeville. Beyond that town the roads were crowded with army transport of every kind, and I did not arrive at St. Omer till 5.30 p.m. on October 13th. It was getting dusk, but inside the town I met Major Poe, R.A.M.C., whom I had last seen at Rouen, and who had arrived in charge of our first motor ambulance convoy. He told me that he was just off "to a place called Hazebrouck," that there had been fighting on a large front that day, and that he expected to bring in 420 wounded. Little did he or I think that this was the opening day of what would ever after be known as the "First Battle of Ypres"!

I had arrived at the nick of time. Early next morning I was at the office of the Medical Department, and found that Col. (later Major-General) Tuckey O'Donnell had recently been appointed to be "D.M.S. Front," and was the senior officer at G.H.Q. at that time. I soon saw him and the A.G., Lieutenant-General Macready, and explained that I had been sent out as Consulting Surgeon, and that I wanted to stay at the front. It seemed to have been generally accepted that the only proper place for all consulting surgeons was the base, but as there were only two of us, and as Sir G. Makins was working hard at Boulogne, I did not have much difficulty in obtaining permission to stay and help with the 420 wounded who had arrived, or were arriving, at No. 1 C.C.S. in the "College de St. Joseph." I was then supposed to have come to G.H.Q. temporarily, but, as it turned out, my stay lasted for the rest of the war.

I have only a few words more to say by way of introduction, but it is necessary to mention that I found the "D.M.S. Front" most helpful in every way and most sympathetic towards my proposals or suggestions. Later on he became the D.D.G. under Sir Arthur Sloggett, and was replaced in 1916 by Sir W. Macpherson when he left us to take up the chief administrative appointment in India. From all these officers I received every assistance and encouragement throughout the war, as I also did from their successors, Sir Charles Burtchaell and Major-General J. Thomson.

I think that my work was all the easier because my previous experience in South Africa enabled me to realise from the beginning that the Army Medical Service was essentially an integral part of the whole Army, and that it must be considered always as a part which was intimately related to various other parts, and could not be considered as if it were a detached unit.

Thus, it was the considered policy of the Army before the war that no wounded should be retained near the front longer than was absolutely necessary, and that consequently they must be evacuated to the L. of C. on the first opportunity. The Army had decided to get the wounded out of its way as soon as it could, and it did not wish to have large hospitals near the front, which would require the transport of food and ordnance supplies on railway lines or roads urgently needed for military stores of every description. It had further to be realised that the "military situation" always dominated everything, and that one must not expect to be always furnished with a reason for decisions opposed to one's own opinions. It is necessary to keep these facts in view in order to realise that radical changes in the

surgery of the front could not be made by the Army Medical Service with a stroke of the pen, and that the decision on many matters did not rest with the Director-General alone, but was a concern of the General Staff also. It is not appreciated by many, for example, that the site of a C.C.S. and the arrangements for the transport of wounded are matters which can only be settled in conjunction with the "Q Branch" of an army, or that the alteration of the whole policy of evacuation of sick and wounded was a matter which interested the General Staff.

Now we come to the ever-famous "First Battle of Ypres." During this fight our army had only a comparatively small number of men in the field, namely, six depleted infantry divisions and three cavalry divisions. I am not going to describe the battle; it would take a great deal more than the time at my disposal, but it began at Hazebrouck on October 13th, and it was continued by the gradual advance of our troops until, in the north, we passed beyond Ypres. The country was at that time very pretty, with sloping hill-sides and woods, and it may interest you to know that at a place called Polygon Wood a number of horses used to be trained for the "International Horse Show" at Olympia. What happened during the next few weeks was that we and the French, and north of us the French Marines at Dixmude, and north of them the Belgians, were fighting very hard to stop an overwhelming mass of Germans, with an equally overwhelming mass of artillery, who attacked on the whole front from Bethune to the sea, and the casualties that we suffered were in no way represented by the number of the wounded. In those days it happened over and over again that whole companies were practically annihilated. They stood their ground, they returned the fire of the enemy, they fought until they died, and that is why there were comparatively few wounded in proportion to the dead. But before they laid down their lives they killed by accurate and rapid rifle fire a sufficient number of Germans to ultimately stop the onset.

We had six clearing stations at work. One was in Ypres, but it was shelled out the first week, and had to be taken to Hazebrouck, which was twenty miles back, and where there was already another. One was at St. Omer, about thirty miles back, and was used as a sort of base hospital. One was at Poperinghe, which is behind Ypres. One was at Bailleul; one was at Bethune. The last three were our only C.C.S. units close to the battle, and the one in Bethune was shelled out before the year ended.

Now let us just look at the situation for one moment, and think of what the C.C.S.'s could do for the 13,000 men who were wounded in this fight. They each consisted of a staff of only six medical officers, a commanding officer, and a quartermaster, and they each had altogether eighty orderlies. They were equipped on plans made during peace, merely with the intention that they should act as places through which the wounded could be passed from the field ambulances into a train, and they were never intended to do operative surgery. They had no beds and only 200 stretchers; they had hardly any instruments; they had each one operating table; they had no sterilising apparatus and very few towels, there were no gloves, there were no gowns. So when I arrived at the front on October 13th I realised that the more numerous field ambulances must do most of the emergency operations, and that anything on a large scale in the way of front-line surgery was impossible for the moment. But it was very evident that as soon as the opportunity came there was much which might be done.

Officially, the first battle of Ypres lasted until November 17th, but it went on for a little longer than that. Towards the middle of November it was suggested that some beds might be got for the worst cases in the C.C.S.'s and we got twenty beds to start with. That was a beginning, but when we got the beds we said—"It is no good having beds for sick patients unless you have nursing sisters"! The latter were not supposed to go to the C.C.S.'s, but when we got the beds we asked for them and said: "Until you have sisters you will not get a sufficiently high ideal of work." We wanted to do things as well as they did them at any great civil hospital; so we got twenty beds to begin with, and we got five nurses to each C.C.S. That was in November, and at Christmas I came back for a few days to London, partly for leave, but I also came back with authority to obtain considerably more equipment for the C.C.S.'s.

So ended 1914, but, although the obvious changes in front-line surgery were but small, the all-important principle had been conceded, namely, that the C.C.S.'s no longer existed merely for the purpose of evacuation, but were allowed to treat, operate upon, and retain wounded men. A small beginning, it is true, but one that contained great possibilities for the future.

1915.

I returned to France early in January, and from that time onwards we began to do regular operating work in C.C.S.'s and to train surgical staffs. At this stage also we had to come to some definite decision as to the lines on which we were going to work. Were we going to ask that a large number of experienced operating surgeons should be sent out from England to take front-line work at the C.C.S.'s, or were we not? I knew that there were many operating surgeons in England who were doing very hard work, and I knew that some of them who could do first-rate work at home were not young enough to stand the racket of C.C.S.'s work night and day, and, if we did get them out to France, others would have to be found to take on their work, so my impression was that we ought to train our own staffs at the front. But I pointed out that it was no good training the staffs unless it was arranged that they should, as far as

possible, not be changed. There is a tendency in all armies to move people about, and you might go to a unit one day and find so and so there; go the next, and find somebody else in his place. Well, from that time onwards we started training some men and casting out others whom we did not find good enough, until we had a satisfactory, capable, energetic lot of young surgeons, and I can never sufficiently express my admiration for the way in which the front-line surgery was done by them.

The next event was that, on March 10th, there came the crowds of wounded from the Battle of Neuve Chapelle. Up to this time the British Army had expected daily to move forwards; the idea always was that we were going to advance, and the consequence was that, because of this idea, the supply of additional equipment to C.C.S.'s was postponed. The main object of the Army was, of course, to beat the Germans, and everything was subservient to that, for the wounded man necessarily takes a secondary place in war. Supplies of munitions and food for the fighting men—that is the first consideration. I did not grumble, but I only tell you the fact that, as far as front-line surgery was concerned, we were necessarily handicapped by the idea that we were going to advance. The next thing that handicapped me personally was that the General Staff had not yet learnt how far it could trust us civilians or our proposals to do operations at the front. When events were leading towards the Neuve Chapelle fight, I knew beforehand that there was going to be a battle, but I was not told anything officially until the battle had actually begun. The fact was that in March, 1915, we had not yet got to the stage when those in authority turned to us and said to the consulting surgeons: "There is going to be a fight; it is going to take place on such a day and in such a place. Make the necessary surgical arrangements, and be ready for the treatment of so many wounded." That all came a little later, when the Ds.M.S. of armies worked with the active co-operation of their respective consultants. So "Neuve Chapelle" arrived, and with it 12,000 wounded for whom there were very few C.C.S.'s. It was impossible, of course, for the latter to deal with the majority of the wounded, nor were they intended to do so, for at that time the policy of the British Army was still the same as that of all the other armies when the war began, *i. e.* "We will not in battle deal with wounded men at the front; operating work has got to be done at the base." And it must be recognised that evacuation to the base was very good and rapid in this battle.

On April 22nd the "Second Battle of Ypres" began. On May 9th our attack on "Festubert" began, and those fights overlapped. There were 60,000 wounded during April and May. During that time we had ten C.C.S.'s at work, and I felt myself that the strain on them was greater than it had been even in the First Battle of Ypres, while the surgeons at the base were no more than sufficient in numbers for their own work. And so we went on during the spring and summer of 1915, training staffs of C.C.S.'s to do the surgical work, putting the C.C.S.'s into huts or tents instead of in houses, increasing accommodation for operations, adding to the equipment, and, as a result, accomplishing all that was surgically necessary during times of comparative calm, but always overwhelmed when there was a great battle.

And then after a short rest came the next battle—"Loos," on September 25th, an attack by the First Army. Before that time my friend Col. Wallace had come out, and he took one section of the front, which was in the area of the First Army, while I carried on in the Ypres section, in the Second Army. Just before the battle of Loos, an "advanced operating centre," as it was called, was created near Bethune, and that deserves to be mentioned because this was the first time an advanced operating centre was pitched in front of existing C.C.S.'s for a battle. Unfortunately it was swamped by the number of cases brought in, and the few C.C.S.'s could not do more work for the wounded than had been accomplished by the C.C.S.'s in previous battles.

During the year 1915 we had had altogether 196,000 wounded, and of these about 50,000 were wounded at Loos, and 60,000 were wounded in April and May at Ypres and Festubert.

After the battle of Loos Col. Wallace and I felt that the time was ripe for a more definite recognition of the value of the front-line surgery, and we therefore asked for an increase of the surgeons in the C.C.S.'s, and especially for reinforcements before heavy fighting began. We pointed out that the C.C.S.'s were now able to do very valuable work at the front so long as we were not overwhelmed, and our proposals were very cordially received by the Director-General.

So the year 1915 closed. It had been a time of disappointment for the Army, because all our expectations of a general advance had come to naught, and now a period of trench warfare had become established. But as far as surgery was concerned the change was advantageous, for we had been enabled to further increase the equipment of the C.C.S.'s since Neuve Chapelle, and to make them into real front-line hospitals. The combatants themselves looked to us for help, and no one actually at the battle front questioned any longer the policy of providing the wounded with prompt surgical treatment. The C.C.S.'s had indeed already won the confidence of the Army, and now they were bound to progress yet further.

1916.

The year 1916 opened very quietly. A Third Army had been formed in the Albert region, with Col. Alexis Thomson as its Consulting Surgeon, and a Fourth Army was in process of creation. It was this increase of the Army

that brought about in April my appointment as "Advising Consulting Surgeon" at G.H.Q., and I was given a sort of roving commission along the whole front, with the duty of advising in all surgical matters. I had already the rank of Surgeon-General, and this was of very great assistance in my new post.

Preparations were beginning for our attack in the Somme region, and I accordingly spent a good deal of time in the area occupied by the Fourth Army, on whose front the fight was to take place. Here I enjoyed the fullest opportunity of hearing from the D.M.S., Surgeon-General O'Keeffe, the arrangements which were being made for the C.C.S. work, and I now had also the advantage of discussing the proposals at first hand.

The chief difficulty was that the railway communications were as yet quite insufficient for all the requirements of the army, and, as supplies and munitions had first claim, it was difficult to get sanction for as many C.C.S.'s as seemed to be necessary. But we were going into a very big fight and the wounded were certain to be very numerous, so the Director-General ultimately arranged for the provision of fourteen C.C.S.'s to hold not less than one thousand men each; some of them could take nearly two thousand, and we provided in addition a very good advanced operating centre for abdominal cases, with about forty beds, near to Albert.

Further, and most important of all, we were able to increase all the surgical staffs before the battle began, and were also allowed to bring to our help the surgical specialists from other C.C.S.'s further north, arrangements which greatly assisted the work of Cols. T. Sinclair and Maynard Smith, who were associated with me as consultants, for it should be mentioned that soon after the fight began our Fifth Army came into being. During this battle I lived at a C.C.S. near to Albert, and took charge of certain areas as a consulting surgeon.

It was well we had made large provision in the C.C.S.'s, for on the first day there were 22,500 wounded, the next day there were 16,000, the next day there were 9000. After that matters eased off, yet the total number of casualties during the battle was over 300,000. It was forntuate also that during this fight we had fourteen medical officers instead of six in each C.C.S., and instead of five nurses we had fifteen; and as the result of the increased staffs, and in spite of the pressure of battle, I had the satisfaction of reporting to the Director-General that we had done 30,000 essential operations under anæsthetics at the front during a period of three and a half months. That brings us to the end of 1916—a year in which front-line surgery made a very great advance and established itself on a sound footing.

1917.

Now we come to 1917. Great encouragement was given to us by the Director-General to materially increase the staffs of C.C.S.'s; but in consequence of the German Army retiring over a large portion of the front, arrangements had to be made in addition for an advanced operating centre behind Arras. The scene of battle had now shifted northwards to the areas of the Third and First Armies, whose consultants were Cols. H. M. Gray and C. Wallace, and whose Ds.M.S. were Surgeon-Generals Murray-Irwin and W. Pike. The surgery had already become everywhere very much more efficient than it had ever been before. The "Thomas" splint, which formed such an important feature in our work was now being universally used by the C.C.S.'s and field ambulances of every army, and it had even gone as far forward as the regimental aid posts in some areas. The best methods of applying it had been thoroughly taught during the winter by all the consulting surgeons, and its use and the use of other new first-aid splints had been demonstrated in every field ambulance as well as in the C.C.S.'s on the whole front. This personal education very soon proved of the greatest possible value.

The battle at Vimy and Arras, which began on April 9th, was fought by our First and Third Armies, and many new C.C.S.'s were provided before it began. It had to be unduly prolonged in order to help the French, who had got into great difficulties on the Aisne, and our prolonged attacking under very unfavourable conditions gave rise to many more casualties than would have occurred if we had only required to do as much as we ourselves wished. But the surgeons of the C.C.S.'s were reinforced by "surgical teams" from other units, comprising a surgeon, a sister and an anæsthetist, and good work was done everywhere.

Then came the "Messines" fight on June 7th, further north still, and when I returned to the Second Army I was glad to find that Col. Gordon Watson was the Consulting Surgeon, and he and I arranged, under Major-General Porter, the D.M.S., for the treatment of the wounded. Well, that was a most completely successful fight. The arrangements of the D.M.S. for bringing the wounded into the "corps dressing stations" and the C.C.S.'s worked most smoothly, and 18,000 men were treated very thoroughly in three days. Most of the C.C.S.'s held as many as 1000 patients and had fifteen nursing sisters. In no previous fight had the wounded done so well.

And then arrangements had to be made with the Ds.M.S. of the Second and Fifth Armies (Surgeon-Generals Porter and Skinner) for the "Third Battle of Ypres"—the "Passchendaele fight"—which began on July 31st, and we were very fortunate in being able to provide for yet larger reinforcements of surgeons than formerly. There had recently arrived a number of American surgeons, and some of them were amongst the very best surgeons in the whole of America. They were not yet required for their own army, and by getting them and a number of our own colonial surgeons—

Australians, Canadians, New Zealanders, and South Africans—we created enlarged and most efficient staffs for the C.C.S.'s, so that each of these had at least twenty-four medical officers, and we were also enabled to double the operating equipment. Each C.C.S. kept eight operating tables at work, and no less than 60,000 wounded were treated under anæsthetics during the fight. That was the best thing that we had yet done, because, as the total wounded in the three and a half months amounted to 196,000, those 60,000 represented about 30 per cent of the whole of the wounded who passed through the C.C.S.'s. It should also be noted that it was during this fight that blood-transfusion was first employed on a large scale. Almost the whole of the necessary operations were done at the front on this occasion, and the result was that never before had the wounded in the general hospitals done so well.

Before this battle had well finished another attack of ours blazed up at Cambrai on November 20th. The Germans replied by an attack on November 30th, and our C.C.S.'s, although they were very near the line of fire at one time, managed to hold on to their sites, and practically all the wounded were adequately treated.

The year 1917 came to an end soon after this battle, and the Army Medical Service could look back on its front-line work with a good deal of satisfaction. The wounded had reached a total of nearly 500,000 in the year, but in spite of such great numbers a far larger proportion of them than in any previous year had been thoroughly treated at the front. The equipment of the C.C.S.'s had become very complete, and the arrangements for reinforcing hard-worked units had been fully tried and not found wanting.

1918.

We entered next upon what proved to be the last year of the war—1918. It began very peaceably; there was nothing doing. I wandered over the front to see that all was in readiness, and found but few wounded anywhere, although we all knew that this was really the calm before the storm. There was subsequently a lot of talk about our being surprised by the German attack, but there was not a word of truth in this statement, for all C.C.S. commanders of the Fifth Army had been warned by the D.M.S., Surgeon-General Skinner, that the attack was impending, and later we got definite information that it would take place on March 21st.

On the morning of that day I started early, and from twenty-five miles away I could hear the roar of battle. I went down to the headquarters of the Fifth Army, and even after eleven o'clock there was so dense a mist on the hills that you could not see 100 yards. It was in that mist that at dawn the Germans had managed to push their way between our outposts, where our line was very thin, for the Fifth Army covered about forty miles of line with only fourteen divisions. I got down to headquarters of the D.M.S. at Nesle, and afterwards went on further forward with the Consulting Surgeon, Col. Maynard-Smith, to a place called Ham. There I found the most advanced of our C.C.S.'s working splendidly, but there had been a fire in the medical stores in the village, and the railway line between this C.C.S. and the next one at Cugny was broken by shell fire. We heard, however, that the patients had been got away to Compiègne, so I went on to a group of C.C.S.'s further north. Here also everyone was working hard, for they were close to the main road leading from St. Quentin, and great numbers of wounded were arriving. On this day and early on the next practically all the wounded were satisfactorily treated in the C.C.S.'s. Afterwards there were many who could not be brought in, because, for one reason, the roads got so blocked with traffic, retiring guns, and innumerable lorries that the ambulance cars which took patients to the C.C.S.'s from the field ambulances could not always get back to the field ambulances to pick up the next load. The result was that a certain number of wounded were necessarily left behind, although not before many of them had been carefully dressed and splinted by the field ambulance staffs. Some Units lost their all, but others saved a great deal of their kit and equipment. Every C.C.S. of the Third and Fifth Armies had to retire, but many of them were reconstituted in the neighbourhood of Amiens and within a day or two were again at work.

The Germans claimed 93,000 unwounded prisoners, but the actual number was, I believe, about 46,000 wounded and unwounded put together, and not a single patient once in a C.C.S. was captured. Wonderful stories went round the base, and even to England, as to the number of people who had been captured, and one rumour said "the whole of No. 00 C.C.S. has been captured with all the staff and the nurses," etc. It was all invention, yet, considering what had happened, it was surprising that there were not more reports of disasters. But then there was a complete absence of anything like a panic.

In only one instance were a few patients left behind, and then they were left in charge of a medical officer and some orderlies. It was the right thing to do at the time, for the capture of the whole staff would not have helped matters. But even in that case some cars and lorries were sent back, and everyone was evacuated before the Germans arrived. Meantime the train service to the base had been first-rate, and the general hospitals received the wounded with but little delay. Fortunately, we had anticipated that the latter would be heavily worked, and more operating theatres and more surgeons were waiting in readiness before the call for action came. The Ds.M.S. and the consulting surgeons of the Third and Fifth Armies, Cols. Gray and Maynard-Smith, had had a very anxious time, but the worst of the pressure was all over within a week, for by the 28th the

retreat had stopped and the German attack had already failed.

The real cause of the failure was the complete defeat of the German assault on the Arras sector on March 28th. After having rushed the south of our line they made a very determined effort to get through further north, at the junction of the First and Third Armies, but there was no mist as there was on March 21st, and our artillerymen were able to get on to their troops where they were massing behind the line, and machine gunners and rifles fired into them as they came nearer. We heard afterwards, what we did not know at the time, that after the attack had failed with tremendous losses Ludendorff abandoned the main offensive, and you will remember that the further German advance towards Amiens never came off.

Fighting continued, however, in April and May in the northern part of the line which we called the "Kemmel area," and also on the Armentières–Bethune front in the region of the Lys, but although some of the C.C.S.'s had to retire, the front-line surgery continued without much interruption in all three armies, and while the people in England were still full of anxiety, we in France were confident that before the summer was out our turn would come to advance ourselves.

You will remember that on May 27th the Germans attacked the French on the Aisne. We also had some divisions down there—divisions which were not up to strength and which suffered very severely, although they held on, and by holding on they helped to prevent Rheims from being taken. But the French were defeated and were driven back beyond the Aisne, and in consequence one of our C.C.S.'s in this region was captured, and as the staff remained so as to care for the wounded, they were captured also.

We now come to July, the month in which the tide of battle began to turn, although the full flood did not run till August. On July 4th—Independence Day—the Americans came into the battle line for the first time near Villers Bretonneux. They had been ordered by their own people to be under our command for the attack, and then at the last moment for some reason the order for them to join in the attack was countermanded. This caused great disappointment, and one section of the Americans behaved as Nelson did when he put his blind eye to the telescope, and "did not hear the counter-orders." The attack was a very successful one; there were not many wounded, and all were easily dealt with by our surgeons.

On July 15th came the last attack of the Germans. They crossed the Marne, but were violently counter-attacked by French, British and Americans on July 18th, and at that time and subsequently some of our C.C.S.'s had very heavy work near the Marne, and were so overfilled with wounded that many of the latter had to be passed on to American and French units for treatment.

It was early in August that I became aware of movements of large numbers of cavalry and guns, all very mysteriously done at night, and I realised that there was something big on foot. But it was only twenty-four hours before it actually took place that I and Col. Gask, the consulting surgeon of the Fourth Army, were told officially that there was to be a big attack by us in the area of the Fourth Army on August 8th.

The warning was short, but the C.C.S.'s were ready in every way, and ample reinforcements of surgical teams arrived in plenty of time, so that when the battle did begin on the morning of August 8th we were quite prepared for it, with plenty of C.C.S.'s and plenty of surgeons. In four days we had about 18,000 wounded.

The attack of August 8th was a complete surprise, as you may remember. It was a surprise to you over here; it was a surprise even to some of the troops who took part in it, and it was a very great surprise to the Germans. That day marked the beginning of our own great offensive, the opening of the greatest battle that has ever been fought, and the beginning of a British advance which ran the Germans to a standstill, and which practically never stopped until the enemy were completely defeated and the armistice was signed.

During the earlier part of the battle the fighting was mostly in the south, but after a short time it spread over the whole line. There was a brief interval after the end of August, and then in September we got back once more to the old position of the Hindenburg Line. When we got as far as that inquiries were set on foot to ascertain whether our troops were over-tired, now that they had fought continuously for six weeks, but all the information pointed to the fact that they were still full of go and keen to attack, so Sir Douglas Haig decided to press home the advance and to attack at all points.

The consequence was that on September 27th, 28th and 29th our great assault took place on the Hindenburg Line, and in the north the Belgians joined in with the Second Army. On the 27th and 28th the Second, Third and First Armies attacked, and finally, on the 29th, the Fourth Army. The result was a universal advance, heavy losses, but a complete destruction of the German *morale*; for now that they were driven back from what they had believed to be an impregnable position the fighting spirit was knocked out of them, although the First, Third and Fourth Armies had some strenuous opposition in very difficult country early in October.

I need hardly remind you that these advances of ours always meant a constant moving and re-pitching of our C.C.S.'s, which had now to leave their huts and some of their equipment behind them and do their work in tents. But before each fresh advance there was generally a little breathing time, and, as everything was planned and thought out beforehand by the various Ds.M.S. and their consulting

surgeons, the C.C.S.'s were generally all well placed and well equipped before the fighting of the next stage began. During the earlier part of our advance the stress of the work fell successively on the Fourth, Third and First Armies, and then on the Second Army. The Fifth Army had not been in the line since the great German attack, and was only just being reinstated when our own attack opened on August 8th. It became engaged in September.

As far as the surgery was concerned there was increasing difficulty in supplying sufficient staffs as more and more of the whole Army became engaged, but almost everywhere the high standard which had been reached was maintained in spite of the difficulties.

A greater trouble was that the C.C.S.'s had often to send some patients to the base before operation or else to evacuate others sooner than was surgically advisable because of the constantly recurring calls to pack up and move on with the victorious troops. It was a penalty of success, and this evacuation to the base was really urgently necessary, because the devastated country and the destroyed railways quite prevented, at the time, the moving forward of the general hospitals.

The Great War was now drawing towards a close, but it was destined not to end until we had crowned our success by an advance in the old "Ypres salient," and here, on October 14th, the Second Army fought for the last time over the old battle-field. The D.M.S., Major-General Guise Moores, pushed up our clearing stations in preparation for this fight, now not only as far as they had been before the previous March retreat, but this time as far as Ypres itself, and we established a group of three at Brielen, just outside Ypres.

I told you that I originally arrived at the Ypres front on October 13th, 1914, and here we were back again on October 14th, 1918, after an interval of just four years. I had heard the first shells come into Ypres, and that day I heard the last. It was interesting to realise that, whereas in 1914 there was no attempt to perform surgical operations at the front on a large scale, in 1918 no less than 40 per cent. of the whole of the patients who were brought to the Brielen C.C.S.'s of the Second Army were anæsthetised and passed through the operating theatres during heavy fighting.

Extraordinary changes had taken place in the treatment of wounded men between the first battle of Ypres in 1914 and the "Last Battle of Ypres" in 1918.

You will remember that when Napoleon returned from Elba there was a campaign which was called "The Hundred Days." The great battle that the British Army began on August 8th and finished on November 11th, and which resulted in the defeat of the Germans and the ending of the war in 1918 instead of continuing through the winter, lasted just about the same time. It will very likely be known in future as "The Hundred Days' Battle of the Great War."

During this period we had more than 300,000 wounded to deal with, but the accumulated experience of many battles and the systematised methods developed by constant practice enabled the work to be done with comparatively little difficulty. It is of course true that at times the C.C.S.'s were overworked, and that the quality of the surgery suffered. This must always occur in great battles because of events beyond the control of the Medical Service. Yet, even when this is admitted, it may still be claimed that the British surgery of the Front showed a continuous improvement in each successive year of the Great War.

THREE CASES FROM LUCAS AND HENRY WARDS.

By C. F. Beyers, M.R.C.S., L.R.C.P.

(1) Case of Fibro-Sarcoma of Musculo-Spiral Nerve.

Sarcomata of peripheral nerves are comparatively rare, and this case is of interest in that a nerve of the upper extremity is affected. These tumours are most commonly found in the nerves of the lower extremity, more than half the recorded cases being sarcomata of the great sciatic nerve.

Frances J—, æt. 19, a book-folder, was admitted to Hospital on June 6th, 1919, complaining of a swelling of the left arm and wrist-drop. She noticed the swelling when she was twelve years old, and suffered no pain or inconvenience from it until a month before admission, when it became painful. It increased in size and she developed wrist-drop. On examination an ovoid swelling as large as a hen's egg was discovered in the left arm at the junction of its middle and lower thirds. It was situated on the outer side of the external inter-muscular septum and beneath the outer head of the triceps. The swelling was solid, and possessed a smooth surface and a clearly defined outline. It was not attached to the bone and was freely moveable from side to side but not in the long axis of the arm. The forearm was not wasted. Marked wrist-drop was present. The electrical reactions of the muscles were as follows: The triceps was normal, the extensor carpi ulnaris and the extensor communis digitorum showed partial R.D., while the other extensors of the wrist and fingers and the supinator showed complete R.D. The musculo-spiral and posterior interosseous nerves were inexcitable.

An incision was made over the swelling and a soft encapsuled tumour connected with the musculo-spiral nerve was discovered. The nerve-sheath was seen proximally to spread out over the tumour and some of the nerve-fibres could be traced into its substance. The tumour was excised

and on section proved to be a fibro-sarcoma. No nerve-fibres were observed in the section.

As the continuity of the nerve was preserved as much as possible, and owing to the fact that the tumour has probably only a local malignancy, the prognosis may be regarded as favourable.

(2) CASE OF CHRONIC INTESTINAL OBSTRUCTION DUE TO CICATRISATION OF AN OLD ULCER OF THE ILEUM.

Albert D—, æt. 26, an international footballer, was admitted to the Hospital on June 7th, 1919.

He was quite well until February, 1919, when he contracted a sore on the penis in Lagos, Nigeria. After an intravenous injection of salvarsan he became very ill, with continuous vomiting, abdominal pain and melæna. From that time he began to lose weight very rapidly. He referred his pain to the lower part of his abdomen, coming on about eight hours after meals, and accompanied by rumbling and gurgling noises. He came to England, and attended at the London School of Tropical Medicine, where an exhaustive examination of his stools, blood and urine was made, but no evidence of tropical disease was discovered. He was given salvarsan again without any ill-results. A Wassermann examination proved to be negative.

On admission to this Hospital he was found to be very emaciated, and suffering from pain and nausea after food with occasional vomiting. His abdomen was distended, and visible persistalsis with borborygmi was present. An X-ray examination was made, and showed considerable delay in the passage from the ileum to the cæcum.

A laparotomy was performed. The ileum was found to be much distended, and on tracing it downwards a constriction was discovered about 12 in. from the ileo-cæcal valve. A lateral entero-enterostomy was performed. The structure was evidently the result of the cicatrisation of an intestinal ulcer, single, circular in outline, and situated on the side of the intestine which is furthest away from the mesentery. The ileum was much distended, and for some inches on the proximal side of the ulcer it was greatly thickened and inflamed. The operation wound was closed without drainage. There was a slight fæcal discharge on the second day, but this ceased on the twelfth day, and the general condition of the patient has improved steadily.

(3) GALL-STONES OR RENAL COLIC.

The following case of repeated attacks of colic associated with a large right-sided abdominal tumour is interesting from the point of view of diagnosis. The question that had to be decided was whether the colic was renal or biliary in origin.

Mrs. Hannah J—, æt. 74, was admitted to hospital on June 26th, 1919. She has always had "bilious attacks," which consisted of headaches and discomfort after meals, but without pain or vomiting. She was slightly jaundiced on one occasion in 1916. She has had increased frequency of micturition for some years. The attacks of colic began three months before admission. The pain was felt in the right side of the abdomen and in the small of the back. There was no jaundice and no vomiting and she says that her stools appeared natural. On the other hand she found that during an attack she would at first pass very small quantities of urine and then a large amount, which appeared to relieve her pain very greatly. She says that her urine became "gritty" during the last week.

On admission her temperature was normal and her pulse 88. She was not jaundiced. Her abdomen was slightly rigid, and a large, tender, moveable tumour could be felt to the right of and slightly above the umbilicus. The tumour could be moved in an upward and side-to-side direction, but not downwards. The outline was rounded and well defined and the surface quite smooth. On palpating the right lumbar region pressure appeared to be communicated to the tumour and *vice versâ*. On percussion the tumour was dull and the dulness was found to be continuous with the liver dulness. A tentative diagnosis of floating kidney with hydronephrosis or less probably of biliary colic was made. On operating through a lumbar incision the right kidney was found to be normal in size and not displaced. The patient was therefore turned over on her back and the usual gall-bladder incision made. A much-distended and inflamed mucocele was discovered, and after evacuating the contents of the bladder a single large stone was found impacted in the cystic duct. Cholecystectomy was performed and the patient made a rapid recovery.

I am indebted to Sir D'Arcy Power, K.B.E., for permission to publish these cases, and to the dresser, Mr. L. M. Billingham, for taking the careful notes which are here summarised.

TWO CASES OF ACUTE INTESTINAL OBSTRUCTION.

By SAMUEL GREEN, F.R.C.S.(Edin.), Waimate, N.Z.

IT is almost necessary to apologise for publishing two cases of such a relatively common catastrophe as "acute intestinal obstruction." The two cases are very similar, in so far as the cause of the obstruction was situated at the terminal portion of the ileum; furthermore the actual lesions found are comparatively uncommon.

Negative signs and symptoms are not mentioned.

Mrs. W—, æt. 44, awoke suddenly at 3 a.m. with a griping abdominal pain. Seen at 6.30 a.m., by which time there had been a second attack.

She seemed to be anxious about herself. Careful examination revealed nothing except slight rigidity of the right

rectus and tenderness down the right side. Temperature and pulse normal.

The idea of operation was not well received, but another attack of pain decided the matter, and the abdomen was opened. The diagnosis was (?) acute intestinal obstruction, Dr. A. G. Pitts assisted.

The abdomen was opened below the umbilicus by pulling the right rectus outwards. Clear fluid escaped, and collapsed intestine noticed. The cæcum was collapsed. The appendix was found tightly bound down by old adhesions; it was removed with difficulty. The collapsed coil of ileum was traced backwards until it disappeared in a fossa behind the cæcum. This fossa contained 18 in. of intestine, which was easily freed. The fossa ran upward behind the ascending colon for about 5 in.; its mouth was obliterated by catgut sutures; whilst this was being done a large vein was pricked. The operation took $2\frac{1}{2}$ hours—far too long! The patient made an uninterrupted recovery.

Mrs. B—, æt. 37, the victim of double inguinal hernia and complete prolapse of the uterus, was suddenly afflicted by a severe pain in the abdomen. This occurred at 7 p.m. At 8 p.m. she vomited. Attacks of pain recurred with vomiting, and continued hourly until 12 mid-day on the following day, when her husband was sufficiently alarmed to send for me.

She was very ill. Temperature 97° F.; pulse 64. The only physical sign she presented was slight tenderness in the R.I.F.; no distension; left hernia down, but reducible right hernia not down. No impulse over the inguinal canal.

She was brought into the hospital and given an enema with a good result of fæces and flatus. This I neglected. Shortly afterwards she vomited about a pint of brownish fluid.

Diagnosis: high obstruction of small intestine.

Owing to unforseen delays the abdomen was not opened until 8 p.m. Dr. E. C. Hayes assisted me. Right paramedian incision 7 in. long, the rectus pulled outwards. Free fluid, straw-coloured. The cæcum was collapsed. The ileum was traced backwards and was found to enter the right inguinal sac, where it formed a Richter's hernia which had been reduced *en masse*. The neck of the sac was thick and fibrous; a small nick in this enabled the gut to escape, together with dark fluid. The gut was dark in colour but soon recovered. The sac was obliterated as much as possible. I was so elated at having found and successfully dealt with the cause of the obstruction that I forgot my diagnosis and closed the abdomen. No flatus was passed for 24 hours and then only a little. Shock was marked. Calomel, pituitrin, eserin and enemata eventually produced bowel movements. The patient recovered.

The ileum between the ileo-cæcal valve and the site of obstruction was marked by fibrous rings, evidently the result of previous strangulations.

It is not meant for one so inexperienced as I am to draw conclusions from cases, but the above have given me three rules for my own guidance.

(1) Don't start fiddling with a chronic appendix when there is obvious intestinal obstruction.

(2) If you make a diagnosis of "obstruction high up" and find "obstruction low down" make certain that the diagnosis was wrong. It saves much worry when the patient passes nothing for 24 hours.

(3) In cases of sudden colicky pains in the abdomen that seem localised and do not suggest renal or biliary colic I shall open the abdomen as quickly as possible and shall hope thereby to save a few lives. The mistakes will be borne with fortitude.

Of course this statement is too broad to be accepted literally.

THE BOWLBY PORTRAIT FUND.

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

DEAR SIR,

Sir Anthony Bowlby will shortly retire from the Staff of the Hospital. It is proposed to present him with a portrait of himself, painted by a well-known artist, as a recognition not only of his services to the Hospital and Medical School of St. Bartholomew, but also as an appreciation, which all Bart.'s men must feel, for the great work that he has done in connection with the A.M.S. during the war. It is felt that all those who have come in contact with him either directly or indirectly would like to subscribe towards such an object, and therefore the notice has been circulated to all old Bart.'s men and students inviting them to do so.

A certain number of these notices have been returned to me owing to the fact that we have some incorrect addresses. I should not like to feel that there may be some who would wish to subscribe and have not received this notice, and am therefore asking you whether you would be as good as to place this letter in the JOURNAL.

It is hoped that all those who are intending to subscribe will do so as soon as possible so that arrangements may be made in selecting the artist who is to make the portrait, as this will largely depend upon the amount of money obtained. It is hoped that we shall be able to employ the services of the best artist possible.

When the portrait is painted it is intended that a meeting should be held to present the portrait to Sir Anthony, together with a list of the subscribers. The permission of the Treasurer and Almoners has been given that the portrait should be hung in the Great Hall of the Hospital amongst those of his illustrious predecessors which already adorn it.

Subscriptions, which should not exceed two guineas,

should be sent to Mr. R. Cozens Bailey at the accompanying address, who will act as Hon. Treasurer of the Fund.

Yours sincerely,

W. GIRLING BALL,

Hon. Sec.

Bowlby Portrait Fund.

WARDEN'S HOUSE,
ST. BARTHOLOMEW'S HOSPITAL AND COLLEGE,
LONDON, E.C.;
June 12th, 1919.

[We understand that the above Fund will shortly be closed.—ED.]

STUDENTS' UNION.

ST. BARTHOLOMEW'S HOSPITAL ROWING CLUB.

A meeting was held on June 13th, 1919, Sir A. A. Bowlby, K.C.M.G., in the chair.

(1) It was decided to revive the Club in 1919, with a view to holding, if possible, an inter-hospital race in September or October, 1919.

St. Bart.'s is the present holder of the challenge cup.

(2) The following officers were elected for the ensuing season:—

President . .	Sir A. A. Bowlby, K.C.M.G.
Vice-President . .	Mr. L. Bathe-Rawling.
Captain . . .	Mr. Kindersley.
Hon. Sec. . . .	Mr. D. C. Fairbairn.

D. C. FAIRBAIRN, *Hon. Sec.*

LAWN TENNIS CLUB.

THE HOSPITAL QUALIFIES FOR THE FINALS OF THE SENIOR AND JUNIOR CUPS.

The Hospital had to meet the Middlesex on June 26th in the Second Round of the Senior Inter-Hospital Cup. The latter's team had a weak tail, though their first pair, Gunasekara and Van Geyzel, was probably the strongest the Hospital has had to encounter.

St. Bartholomew's started well by winning all six Singles, the most even of these being between C. H. Gunasekara and W. D. Urwick, in which the latter just pulled through in the final set by 6–4. Score: 7–5, 5–7, 6–4.

Despite the fact that J. G. Johnstone, had disposed of Van Geyzel (7–5, 5–2), Johnstone and Urwick lost to Gunasekara and Van Geyzel in the Doubles after an exciting three-set match; but the Hospital second pair, C. F. Krige and H. D. McCall, after losing the first set (9–11) against this Middlesex first pair, won the second and third sets easily, Gunasekara being tired out by the final set and rarely getting to the net.

Owing to King's College Hospital scratching, the Hospital has now to play St. Thomas's in the Final.

The Second tennis six, captained by H. A. Douglas, have beaten St. Thomas's and the U.C.H. in the First and Semi-final Rounds of the Junior Inter-Hospital Cup, and so have qualified to meet Guy's in the Final.

RESULTS.

June 21st: St. Bartholomew's lost to Guy's by 4 Matches to 5 in a friendly match played at Honor Oak.

June 25th—First Round of Junior Inter-Hospital Cup: Played at Chiswick. St. Bartholomew's beat St. Thomas's by 4 matches to 2 in the Singles and 4 matches to 2 also in the Doubles.

June 26th—Second Round Senior Inter-Hospital Cup: Played at Winchmore. St. Bartholomew's beat the Middlesex by 6 Singles to love and by 6 Doubles to 1.

June 28th: St. Bartholomew's beat the Cumberland Club "B" by 5 matches to 4.

July 10th—Semi-final Round Junior Cup-tie: At Perivale. St. Bartholomew's beat U.C.H. by 3 Singles to 2 and 5 Doubles to 2.

Semi-final Round Senior Inter-Hospital Cup: King's College Hospital scratched.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

M.S.—R. O. Ward.

CONJOINT EXAMINATION BOARD.

Final Examination. July, 1919.

The following have completed the examination for the Diplomas of M.R.C.S. and L.R.C.P.: S. M. Cohen, P. C. Collyns, J. C. Davies, C. Dunscombe, T. G. Evans, H. J. Levy, G. J. Sophianopoulos, B. M. G. Thomas.

APPOINTMENTS.

HARRIS, H. G., M.D., B.S.(Durham), M.R.C.S., L.R.C.P., appointed Medical Officer to the Ordnance Survey Office, Southampton.

LISTER, A. E. J., M.B., B.S.(Lond.), F.R.C.S.(Eng.), Major I.M.S., appointed an Honorary Surgeon to His Excellency the Viceroy and Governor-General of India.

ROBERTS, A. H., M.R.C.S., L.R.C.P., appointed Certifying Surgeon, under the Factory and Workshop Acts, for Malling.

SLADDEN, A. F., M.D., B.Ch.(Oxon.), appointed Pathologist to the Swansea General Hospital.

SMYTHE, G. A., M.D.(Cantab.), appointed Obstetric Physician to the Royal Hants County Hospital.

WADE, R., M.R.C.S., L.R.C.P., appointed Assistant Administrator of Anæsthetics, St. Bartholomew's Hospital.

CHANGES OF ADDRESS.

BOODLE, G. A., The Cottage, Pearcroft Road, Stonehouse, Glos.
CLARKE, A. J., 25, Caversham Road, Kentish Town, N.W. 5.
FISON, J., 9, North Park Road, Harrogate.
GIBSON, R. W. B., Crown Mines, Johannesburg, South Africa.
GRANGE, C. D'O., 104, Station Parade, Harrogate.
HUMPHRY, A. M., St. Aubin, Jersey.
MARTIN, E. L., 127, Prince's Avenue, Hull.
PAIN, B. H., Fairlawn, Park Road, Southborough, Kent.
RAIL, W. A., 272, Wightman Road, Hornsey, N. 8.
SLADDEN, A. F., Cheltenham House, Eaton Grove, Swansea.
SMYTHE, G. A., 41, Southgate Street, Winchester.
WHITE, C. P., 3, Draycott Place, Cadogan Gardens, W.

BIRTHS.

FERGUSON.—On July 23rd, at Saxstead, Marshall's Road, Sutton, the wife of John Ferguson, M.B., B.S.(Lond.), Park Road, Cheam, Surrey, of a son.

WILLIAMS.—On July 2nd, at Broome Cottage, Bedlington, to the wife (*née* Joan O'Callaghan) of F. S. Williams, M.B., B.S.(Lond.)—a daughter.

MARRIAGES.

BATTEN—TURNBULL.—On July 23rd, at Essex Church, Notting Hill Gate, W., by the Rev. J. H. Weatherall, Capt. Lindsey Willett Batten, R.A.M.C., elder son of Dr. and Mrs. Rayner Batten, of Campden Lodge, Campden Hill Road, W., and 9, Wimpole Street, W., to Ellen Mary, elder daughter of Dr. and Mrs. G. Lindsay Turnbull, of 47, Ladbroke Square, W., and granddaughter of the late James Freeman, of Norwich.

ORR-EWING—ROSS.—On July 16th, at Parbold, by Rev. W. Seaman, Archibald Orr-Ewing, M.B., B.C.(Cantab.), elder son of Mr. and Mrs. Archibald Orr-Ewing, of Weston-super-Mare, to Gladys Mary, second daughter of Mr. and Mrs. Alex. Ross, Parbold.

DEATHS.

CARTWRIGHT.—On June 23rd, 1919, at Oswestry, John Peploe Cartwright, M.R.C.S.(Eng.), aged 70.

PENNY.—On April 25th, 1919, George Town Penny, of 9, Alexander Road, Ulverston, Lancs.

RANDALL.—At 54, Park Street, Bridgend, Wyndham Randall, L.R.C.P.(Edin.), M.R.C.S.(Eng.), aged 72.

St. Bartholomew's Hospital Journal.

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

VOL. XXVI.—NO. 12.] SEPTEMBER 1ST, 1919. [PRICE SIXPENCE.

CALENDAR.

Fri., Aug. 29.—Dr. Morley Fletcher and Mr. Rawling on duty.
Tues., Sept. 2.—Dr. Drysdale and Mr. Gask on duty.
Fri., ,, 5.—Dr. Tooth and Sir D'Arcy Power on duty.
Tues., ,, 9.—Sir A. Garrod and Mr. Waring on duty.
Fri., ,, 12.—Dr. Calvert and Mr. McAdam Eccles on duty.
Tues., ,, 16.—Dr. Morley Fletcher and Mr. Rawling on duty.
Fri., ,, 19.—Dr. Drysdale and Mr. Gask on duty.
Tues., ,, 23.—Dr. Tooth and Sir D'Arcy Power on duty.
Fri., ,, 26.—Sir A. Garrod and Mr. Waring on duty.
Tues., ,, 30.—Dr. Calvert and Mr. McAdam Eccles on duty.

Old Students' Dinner.

Wed., Oct. 1.—**Winter Session begins.**
Fri., ,, 3.—Dr. Morley Fletcher and Mr. Rawling on duty.
Tues., ,, 7.—Dr. Drysdale and Mr. Gask on duty.

EDITORIAL NOTES.

WITH the publication of this issue we come to the end of another Hospital year, and, as on previous occasions, we have recounted briefly in our retrospect some of the outstanding events during this period. The war is over, and peace is definitely signed. The part played by the Hospital has been a great and glorious one, and some day we hope to tell the full story. But it is the immediate future which concerns us at the moment. During the past few months the Hospital has been gradually getting back to its pre-war condition, but, curiously, the process has not been a rapid one. Perhaps it is that men are tired after their exertions of five years' war, but with the advent of the new academic year we have every confidence that Bart.'s will once more get into its stride.

* * *

We wish to take this opportunity of again thanking the several Bart.'s men who during the past year have favoured us with contributions to these pages. It is no light task to run a journal even on the modest lines of this publication. Unfortunately the Editorial department is by no means alone in its responsibilities. The increased cost of labour is a very serious problem indeed, and more than makes up for any decrease in the cost of materials.

We do wish to appeal for support, financially and otherwise. In our editorial capacity we shall be most grateful for any contribution. The Publication Committee will be equally grateful for financial support. The success of the Hospital JOURNAL largely rests with past and present Hospital men, and we confidently believe they will not fail us.

* * *

It is with great regret that we learn that Sir Wilmot Herringham, K.C.M.G., C.B., has resigned his position as Senior Physician to the Hospital. Sir Wilmot is entitled to a rather special token of memory on the part of old St. Bartholomew's men in that he was the first President of the reconstructed Students' Union, and it is largely owing to him that the clubs have reached the very highly efficient state which they do at the present time.

He was also at one time in charge of the Officers' Training Corps, in which he took a very special interest. Outside the Hospital he attained the high office of Vice-Chancellor of the University of London and consulting Physician to the armies in France. In the early days of the war he commanded the First London General Hospital.

We feel that Sir Wilmot has always been a students' man, and we wish him long life and happiness.

* * *

Our warmest congratulations to Lieut.-Col. H. Gilbert Barling on the baronetcy bestowed upon him in connection with the Birthday Honours. Col. Barling is Vice-Chancellor of Birmingham University, where he has been Ingleby Lecturer and Dean of the Medical Faculty. He has also been Examiner in Surgery at the University of Cambridge, and has done very good work in connection with the war.

* * *

Fleet-Surgeon Alfred T. Corrie, R.N., has been elected a Governor of this Hospital.

* * *

We are pleased to congratulate Col. E. M. Hassard, A.M.S., and Col. H. S. Thurston, C.B., C.M.G., R.A.M.C., on being awarded the Military Order of Avis (Portuguese).

* * *

The following Bart.'s men have been mentioned in Despatches from the Commander-in-Chief in India: Lieut.-Col. H. G. Winter, R.A.M.C., Major F. A. H. Clarke, R.A.M.C.

* * *

We owe an apology to Temp. Capt. R. Foster Moore, who was awarded the O.B.E. in the recent Birthday Honours. Mr. Foster Moore as Assistant Ophthalmic Surgeon should, of course, have been included in the list of names of members of the Hospital Staff which appeared in the July issue, and we much regret the omission.

* * *

Sir Robert Armstrong-Jones, M.D., C.B.E., Lecturer on Psychological Medicine at this Hospital, has been appointed a Deputy Lieutenant of the County of Carnarvon.

* * *

We are pleased to see the Old Students' Dinner is again to hold its meeting on September 30th.

We are very sorry to learn that it is to be held at Princes' Restaurant and not in the Great Hall of the Hospital as usual, but we understand there is some difficulty in arranging for the provision of food within the Hospital precincts.

Dr. W. S. A. Griffith is to be the Chairman on this occasion, and we trust that the meeting will be a "bumper" one—in fact, a re-union of all the Bart.'s men after the war.

* * *

At a recent meeting of the Royal College of Physicians of London the following appointments were made:

Censors.—Sir Wilmot P. Herringham, Sir Humphry D. Rolleston.

Treasurer.—Sir Dyce Duckworth.

Registrar.—Dr. J. A. Ormerod.

Harveian Librarian.—Dr. T. H. A. Chaplin.

Curator of the Museum.—Dr. A. T. Davies.

Examiners:

Chemistry.—Dr. W. H. Hurtley.

Medical Anatomy and Principles and Practice of Medicine.—Dr. J. Calvert, Dr. W. A. Turner, Dr. A. J. Hall.

Tropical Medicine.—Dr. J. B. Christopherson.

Dr. F. W. Andrewes was re-elected a member of the Executive Committee of the Imperial Cancer Research Fund.

Sir W. Church was reappointed a member of this Fund.

* * *

The following appointments have been made in connection with the Hospital:

Demonstrators of Practical Surgery: W. Girling Ball, F.R.C.S., and J. E. H. Roberts, O.B.E., M.B., F.R.C.S.

Demonstrator of Operative Surgery: Sir Charles Gordon Watson, K.B.E., F.R.C.S.

Demonstrator of Midwifery: M. Donaldson, M.B., F.R.C.S.

Demonstrator of Biology: W. A. Cunnington, M.A., Ph.D.

Demonstrator of Chemistry: J. H. Johnston, M.Sc.

Demonstrator of Physics: F. Ll. Hopwood, D.Sc.

Senior Demonstrator of Anatomy: J. L. Shellshear, D.S.O., M.B., Ch.M.(Sydney).

Demonstrators of Anatomy: R. A Ramsay, M.Ch., M.B., F.R.C.S., H. E. Griffiths, M.B., B.S., F.R.C.S., J. B. Hume, M.R.C.S., L.R.C.P.

Senior Demonstrator of Physiology: J. Trevan, M.B., B.S., M.R.C.P.

Demonstrators of Physiology: N. B. Dreyer, R. Hilton.

Demonstrators of Pathology: R. G. Canti, M.B., B.C., T. Joekes, M.B., E. G. D. Murray, O.B.E.

Curator of the Museum: T. H. G. Shore, M.D., B.C.

* * *

We regret to announce the death, in his 73rd year, of Dr. Wyndham Randall, Bridgend, which occurred on July 17th. He was educated at Cheltenham and at this Hospital. Dr. Randall was the *doyen* of the profession in the district; he spent nearly the whole of his professional life in his native town, and by his many sterling qualities won the confidence of his colleagues. To within a few years of his death he was medical officer to the Bridgend and Cowbridge Board of Guardians, and medical officer o health to the Bridgend Urban District Council and also to the Penybont Rural District Council. The loss of a son—a captain in the R.A.M.C.—in the war was a blow from which he never recovered.

Dr. Randall was deeply interested in all matters appertaining to his profession, a thoughtful and regular reader of current medical literature. Though he held strong and decided views on many controversial questions, both political and otherwise, views not always accepted by his friends, yet however much they differed from him none doubted his sincerity and all loved his companionship.

* * *

We also regret to have to record the death of Dr. Lovell Drage, which took place at Hatfield on August 15th, after a brief illness. Born in 1859, he was educated at Winchester, and, going up to Christ Church, took a science degree in 1881. At Winchester he was a distinguished rifle shot, and was one of the team that won the Ashburton Shield in 1875. From Oxford Dr. Drage proceeded to Owen's College for a course of pure science. His career at this Hospital procured for him the appointment of House-Surgeon, under the late Sir Thomas Smith, and another appointment under the celebrated obstetrician, Dr. J. Matthews Duncan. He was medical officer of Health for the Hatfield Rural District and coroner for Mid Herts, staff surgeon of the Herts Constabulary, and medical officer of the Herts Yeomanry. He was the author of *Chemical Treatment of Cancer* and other medical works.

OUR RETROSPECT.

ON the occasion of our last retrospect war was still raging, although at the time of writing the Allies were carrying all before them and victory appeared to be well in sight. Soon after the Armistice was signed, men began to come back to the Hospital, but it was not until the New Year that there was any marked ingress of students. The commencement of the Summer Session showed a very large entry, in spite of the fact that the Medical School Committee decided not to admit women as Hospital students.

Quite a feature of the Summer Session was the large number of Overseas Post-graduates. So numerous were they at times that some of the departments were quite crowded out, and we are afraid that in more than one instance students had to take a back seat. Nevertheless we welcomed them at the Hospital, especially the Colonial and American "medicos," and trust they will carry back to their native lands pleasant memories of London's Senior Hospital.

Towards the end of May practically all the Staff had returned, much to the satisfaction, and perhaps we might add, relief of the very hard-worked members who had carried on so admirably during their absence.

Major-General Sir Wilmot Herringham lectured on two occasions during the Summer Session, his subjects being "Trench Fever" and "Gas Poisoning."

Major-General Sir Anthony Bowlby's reappearance when he delivered his first lecture since the outbreak of war was also a notable occasion, and was undoubtedly the best-attended lecture at the Hospital during the year.

We much regret that both Sir Wilmot and Sir Anthony have since tendered their resignations as members of the Hospital Staff.

The Hospital has also lost another valuable teacher in the resignation of Mr. R. Cozens Bailey from the Surgical Staff.

Unfortunately the cessation of hostilities in November did not see the close of the Roll of Honour, and several deaths whilst on active service occurred after that date.

The decorations in connection with the war have been very numerous, and most of them have been referred to in our editorial columns. The list includes the following: K.C.B., 1; K.C.M.G., 2; K.B.E., 3; Knight Batchelor, 1; C.B., 4; C.M.G., 3; C.I.E., 3; C.B.E., 21; M.B.E., 4; O.B.E., 56; D.S.O., 8; Bar to the M.C., 4; M.C., 19; Mentioned in Despatches, 127; Board of Trade Bronze Medal for Saving Life at Sea, 1; Promotion, 11; Chevalier of Legion of Honour, 1; Chevalier Ordre de Leopold, 2; Croix de Chevalier of Legion of Honour, 1; Croix de Guerre, 7; Cross of Chevalier of the Order of the Crown, 2; Order of the Rising Sun (Fourth Class), 1; Order of St. Sava, 1; Italian Bronze Medal, 1; Associate of the Order of St. John of Jerusalem, 1; Civil Honours, 50.

Reconstruction has been very much in the air since the beginning of the year. The May issue of the JOURNAL was entirely devoted to this most important part of the future of the Hospital, and while no actual details can yet be published, we have reason to know that many sound schemes have been formulated and will shortly be launched. It is, indeed, very satisfactory to know that Bart.'s again takes a first place in the advancement of medicine in the world's greatest city.

We have already referred to the large entry of students, and naturally this has meant a revival of the social side of the Hospital. The Rugby team had an exceptionally successful season. The Cricket, Tennis, Rowing, Boxing and other clubs have also demonstrated that the Hospital is getting back to pre-war conditions. Other social functions which have been revived to the delight of everyone have been the Annual Dance and the Past and Present Cricket Match, both of which were a great success.

A notable event of the year has been the very determined effort which the Hospital has made and is making to build a new Home for the Nurses. This has long been a very serious need, but thanks very largely to the energies of Lieut.-Col. W. McAdam Eccles the prospect of a new building in the near future is definitely assured.

It is with much regret that we have to record the death of several past students. We would especially mention the death of two of the most brilliant of the younger members of the Hospital Staff—Dr. A. E. Stansfeld and Mr. Harry Blakeway. There is no doubt that the highest which medicine and surgery had to offer was at their command, and both the Hospital and the medical profession at large are the poorer by their loss.

Another very sad loss to the Hospital has been the death of Mr. Arthur Watkins, who for twenty-four years had acted as Steward to the Hospital. No public institution ever had a more faithful servant. The crowded gathering at the memorial service which was held at St. Bartholomew's-the-Great bore eloquent testimony to the esteem in which he was held.

Many honours, recognitions and appointments have been conferred upon Bart.'s men during the year which add credit to the Hospital. Amongst these we may mention the following:

Major R. C. Elmslie has been appointed Honorary Surgeon to the National Orthopædic Hospital.

Prof. F. A. Bainbridge has been elected a Fellow of the Royal Society.

Sir Norman Moore has been re-elected President of the Royal College of Physicians of London and has also had a Baronetcy bestowed upon him.

Dr. A. E. Gow and Dr. P. Hamill have been elected Fellows of the Royal College of Physicians of London.

Major-Gen. Sir Anthony Bowlby has been awarded the K.C.B.

Major-Gen. Sir Wilmot Herrington has been awarded the K.C.M.G.

The K.B.E. has been conferred upon Lieut.-Col. D'Arcy Power and Col. Gordon Watson.

The C.B.E. has been awarded to Lieut.-Col. J. Calvert, Lieut.-Col. Sir Robert Armstrong-Jones, Lieut.-Col. M. H. Gordon and Major R. M. Vick.

Major F. W. Andrewes, Major R. C. Elmslie, Major J. E. H. Roberts and Capt. R. Foster Moore have been awarded the O.B.E.

Sir Anthony Bowlby has been elected a Vice-President of the Royal College of Surgeons of England.

Sir George Newman has been appointed Chief Medical Officer of the newly-formed Ministry of Health.

The Hospital has again been very successful in regard to the various examinations.

At the University of Oxford one has taken the degree of M.D. and one the degree of M.Ch.

At the University of London one has taken the degree of M.D., and eight have taken the degree of M.B., B.S., one gaining the Gold Medal. At the Royal College of Physicians five have been elected Fellows, and two have obtained the M.R.C.P.

At the Royal College of Surgeons of England seven have obtained the F.R.C.S., while eight have passed the examination for the Primary F.R.C.S. Two members have obtained the D.P.H. One has obtained the Diploma in Tropical Medicine.

Of the Conjoint Board Examinations thirty-two have obtained the Diplomas of M.R.C.S., L.R.C.P.

The Scholarships and Prizes during the year 1918–1919 have been awarded as follows :

Lawrence Scholarship.—G. Bourne.
Luther Holden Scholarship.—No award.
Brackenbury Medical Scholarship.—S. M. Cohen.
Brackenbury Surgical Scholarship.—W. E. H. Banks.
Kirkes Scholarship and Gold Medal.—Not awarded.
Matthews Duncan Prize.—W. S. Sykes.
Willett Medal.—S. M. Cohen.
Walsham Prize.—W. E. H. Banks.
Bentley Prize.—Not awarded.
Hichens Prize.—Not awarded.
Wix Prize.—Not awarded.
Sir George Burrows Prize.—J. V. Landau.
Skynner Prize.—G. Slot.
Shuter Scholarship.—R. Hilton.
Junior Scholarships: Biology, Chemistry, and Physics.—(1) H. Burt-White, (2) N. E. Laurence.
Junior Scholarships: Anatomy and Physiology.—(1) A. Walk, (2) A. C. Maconie.
Harvey Prize.—(1) W. M. Mitchell (prize), (2) F. C. Capps, (3) H. Shannon.
Senior Scholarship in Anatomy, Physiology, and Chemistry.—W. E. Lloyd.
Junior Practical Anatomy (Treasurer's Prize).—(1) A. H. C. Visick (prize), (2) A. Q. Wells, (3) A. W. Hart-Perry, (4) S. J. Davies and E. Coldrey *æq.*
Senior Practical Anatomy (Foster Prize).—(1) F. C. W. Capps (prize), (2) D. M. Lloyd Jones, (3) B. L. Jeaffreson and W. E. Cloyd *æq.*
Senior Entrance Scholarship in Science.—C. L. Pasricha.
Junior Entrance Scholarship in Science.—B. M. Tracey.
Entrance Scholarship in Arts.—J. Maxwell.
Jeaffreson Exhibition.—N. E. Laurence.

MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.,

(*Continued from page* 116.)

DISEASES OF THE KIDNEY.

(116) *Pace* physiology one is tempted to say that there is no such thing as "normal" urine. It is certainly wisdom in the beginner to accept this axiom in the routine examination and description of his patients.

(117) The disposition of "renal" œdema is determined in the first place by looseness of the cellular tissues, and in the second place by gravity; the disposition of "cardiac" œdema is determined in the first place by gravity, and in the second place by looseness of the cellular tissues. "Renal" œdema is first apparent, or is more marked, in the early morning; "cardiac" œdema is first apparent, or is more marked, in the evening.

(118) It is quite common to find concurrence of chronic nephritis and dilatation of the heart. Even so, it is important to determine which factor is the more dominant one in the case, because, if such determination is possible, the appropriate treatment can be more readily undertaken.

(119) Both chronic nephritis and dilatation of the heart may lead to a scanty, albuminous urine. But in the case of chronic nephritis the scanty urine is usually pale—pigment elimination being diminished,—is free from, or has but a small, deposit, the amount of albumen is considerable, and renal casts are present. Whereas in dilatation of the heart the scanty urine is generally high coloured, contains a large uratic deposit, the amount of albumin is usually low, and renal casts are absent.

(120) In nephritis arterial tension rises before albuminuria appears, and for some time before arteriosclerosis shows itself—a clinical observation that preceded the introduction of the sphygmomanometer by many years. Similarly, in nephritis the heart is affected before there are any signs of cardiac hypertrophy. This heart "irritability" shows itself by shortness of breath, palpitation, præcordial distress and night starts on the subjective side, and by arrhythmia on the objective side. These are functional disturbances, and they subside before any structural changes take place if renal adequacy is restored within reasonable time.

(121) It is a common practice to attempt to "flush the kidneys" in certain cases of nephritis in which the secretion of urine is diminished. But experience does not justify this measure. Nor does theory, for in acute nephritis the use of copious drinks contravenes the main indication, which is to secure physiological rest of the inflamed organ, and the renal elimination of water is a vital, and not a mechanical, process; whilst in chronic nephritis such treatment tends to increase existing œdema, or to induce it if not already present. *The time to increase the fluid ingested is when diuresis begins, not before it has commenced.*

(122) The French have a maxim by which they express the urgent necessity of strict adherence to a diet of milk in any case of nephritis in which there is the least suggestion of acute uræmia: *lait ou mort.* The fear of starvation is so deeply rooted in the English mind that it is sometimes necessary, in order to secure co-operation, to meet this fear by arousing another of a worse contingency. Even when the decision to confine the diet to milk is agreed upon the whole question is not settled: the matter of quantity is equally important; 30 oz. *per diem* should be the limit in an adult, and half that quantity in a child. The total amount of fluid allowed should not exceed twice these amounts (*vide* § 120).

(123) The use of a saltless diet in cases of renal œdema, though it has not justified the enthusiasm with which French physicians originally advocated it, is yet a helpful adjunct in treatment.

(124) Decapsulation of the kidneys in the treatment of nephritis has fallen almost entirely, but probably quite undeservedly, into disrepute. Like many another therapeutic measure it was killed by its friends, who advocated it without sufficient forbearance. Its success turns upon the careful choice of suitable cases. Given a case of subacute nephritis, or a case of acute nephritis which is tending to become chronic, in which dropsy is persistent, in which structural cardio-vascular changes are absent or are present only in slight degree, and in which thorough treatment on general lines has failed to establish a cure in three months—in such a case the operation should be seriously entertained, The mortality of the operation in such a case is negligible. and the results more than justify the procedure.

(125) The known presence of a calculus in the kidney or in the urinary tract is not in itself an indication for surgical treatment. But if, in spite of general measures, (i) chronic pain or attacks of colic persist, (ii) hæmaturia recurs, or (iii) the urine becomes infected, operation should be advised.

(126) Tuberculosis of the kidney most often begins in the apex of a pyramid. This accounts for the frequency with which hæmaturia is the first sign, or one of the earliest signs, of the disease. The hæmaturia often intermits, and the urine may be quite healthy between the attacks. The hæmorrhage may be induced by exercise and may be checked by rest. The analogy with calculus in these respects is sometimes very striking, and occasionally they may be rendered even closer by the occurrence in renal tuberculosis of pain of a colicky nature.

(127) The key to many intractable cases of *B. coli* infection of the urinary tract is often to be found in the state of the bowel.

(128) The occurrence of epididymitis as the result of *B. coli* infection is not widely known; the affection is therefore often attributed erroneously to gonorrhœa or to tuberculosis.

A CASE OF AURICULAR FLUTTER: THE EFFECT OF TREATMENT BY DIGITALIS.

By I. DE BURGH DALY, M.A., M.B., B.Ch.(Cantab.),
Captain, R.A.F. Medical Service.

IN a paper published by G. Bourne in the *St. Bartholomew's Hospital Journal* for May, 1918, a case of auricular flutter was described and an account given of the result of treatment by digitalis.

The patient was discharged from hospital in December, 1917, and readmitted in September, 1918, when further treatment was carried out, the effect of which forms the subject of this paper. A *résumé* of the paper by G. Bourne has been added to allow of a clearer conception of his condition which led up to readmission.

[*Résumé.*—J. B—, æt. 60, cigarette maker, had suffered from chronic bronchitis for twelve years. In May, 1916, he had a sudden sensation of weakness in both legs, associated with pain in the upper part of the chest. The pain was of maximum intensity behind the angle of Ludovici of the sternum, but radiated to the left shoulder and down the back of the left arm. He recovered in a few minutes, and the pain disappeared. Similar attacks occurred, until one more severe than the others brought him to hospital on November 1st, 1917. On admission his pulse was uncountable; he was cyanosed and very short of breath. A day later his pulse was 140, regular, and did not vary with posture or exercise. The chest was emphysematous in shape; examination of the lungs revealed the presence of scattered *râles*. The area of cardiac dulness was increased both to the right and the left; there was no ascites or œdema. The liver was not enlarged, and the urine was free from albumen. Sixty minims of tincture digitalis *per diem* were administered, but the failure of this drug to reduce the pulse-rate led to the suspicion of the presence of an abnormal auricular rhythm. An electro-cardiogram showed auricular flutter; the auricular and ventricular rates were 280 and 140 respectively. The P-R interval was ·26 of a second. An attempt to produce auricular fibrillation by larger doses of digitalis was successful, but on the withdrawal of the drug the auricular flutter returned. A second attempt, made with still larger doses of digitalis, again produced fibrillation of the auricles, and was followed by the normal sequence of cardiac events. Details are given in Chart A 1, II. The patient was discharged on December 15th, 1917, feeling much improved in general health.]

In March, 1918, he had another attack of weakness and pain—the first since he left hospital in December, 1917. He complained that the slightest exertion made him very short of breath and easily tired. On clinical evidence alone it was thought that a recurrence of auricular flutter was the cause of his symptoms. Unfortunately it was not possible to take an electro-cardiogram at this date, but in the following June and August two records were obtained by G. Bourne, both of which showed auricular flutter.

From March to September, 1917, the attacks of weakness took place at intervals of about one month. Treatment during this period was confined to tincture digitalis, 45 minims *per diem* being taken. Owing to domestic difficulties he was unable to enter hospital as an in-patient until September 18th, 1918.

On admission he was slightly cyanosed: the veins of the neck were full and appeared to be "fluttering." The area of cardiac dulness extended 4 in. from the mid-line in the fifth space to the left and 1½ in. in the fourth space to the right. The heart-sounds were distant; no bruits were heard. The pulse was 72 per minute and almost regular; rarely "dropped beats" occurred, but premature beats were absent.

He had a troublesome cough, and was expectorating a small amount of muco-purulent material. Scattered *râles* were heard all over the chest. There was no œdema, ascites or albuminuria. There was no orthopnœa.

On the evening of admission polygraph tracings were taken. The effect of respirations and pressure upon the vagus in the neck were observed. Auricular flutter was present with varying 3 : 1 and 4 : 1 heart-block. The auricular rate was approximately 270 per minute (I).

On September 19th an electro-cardiagram (II) showed auricular flutter with 4 : 1 heart-block, 2 : 1 heart-block occurring at irregular intervals. The auricular rate was 300, and the P-R interval ·25 of a second.

On September 20th 60 minims of tincture digitalis were given, the dose being increased to 90 minims on the following day. The chart (III) represents the amount of digitalis taken *per diem* with the resulting changes of rhythm. Auricular fibrillation appears to have been produced on the fifth day from the commencement of digitalis administration, lasted approximately eleven days, and was followed by the normal sino-auricular rhythm.

It was uncertain as to the exact time auricular fibrillation supervened. On the fourth day of the digitalis course the pulse was irregular and 65 per minute; all the beats were coming through to the wrist and there was no change in rhythm after exercise. The irregularity was presumed to be due to varying degrees of heart-block. On the following day exercise increased the irregularity; the rate also rose from 62 to 74 per minute. A few of the beats were not coming through to the wrist and auricular fibrillation was presumed to have occurred. The difficulty of accurately ascertaining the time of change of rhythm is discussed later.

Clinically, auricular flutter associated with varying grades of auriculo-ventricular block closely simulates auricular fibrillation, especially when large doses of digitalis are being taken. There is some reason to believe that the explanation is partly to be found in the comparatively slight ventricular irregularity present during the earlier periods of fibrillation, when large doses of digitalis are being taken, as compared with the later periods when digitalis has been discontinued. Again, the reaction to exercise when auricular fibrillation is present is less marked if digitalis is being taken in large doses.

On September 27th an electro-cardiogram confirmed the change to auricular fibrillation (III).

The return to normal sino-auricular rhythm took place on October 4th. At 11.30 a.m. on that date the pulse at the wrist was irregularly irregular, but at 4.30 p.m. it was evident that a dominant rhythm had set in although there were a few irregular periods; respiratory arrhythmia was well marked. The following day an electro-cardiogram showed normal cardiac events (IV).

From October 11th to 21st 90 minims of tincture digitalis *per diem* were given to discover if a further course would enable him to remain free from auricular flutter for a longer period than three months. During the administration the pulse was always quite regular and never fell below 55; very few subjective symptoms were experienced. He was discharged on October 25th feeling very much improved.

DIGITALIS.

It is of interest to note the relationship between the amount of digitalis, the period over which it was given, and the consequent changes in the auricular rhythm. The onset of a different rhythm was estimated clinically.

The total quantity of digitalis taken before the onset of auricular fibrillation at the second and third attempts (A II, B III) was between 300 and 400 minims of the tincture. In the first attempt (A I) between 400 and 500 minims were taken, the larger amount probably being necessary because of the inadequate doses administered on the first three days.

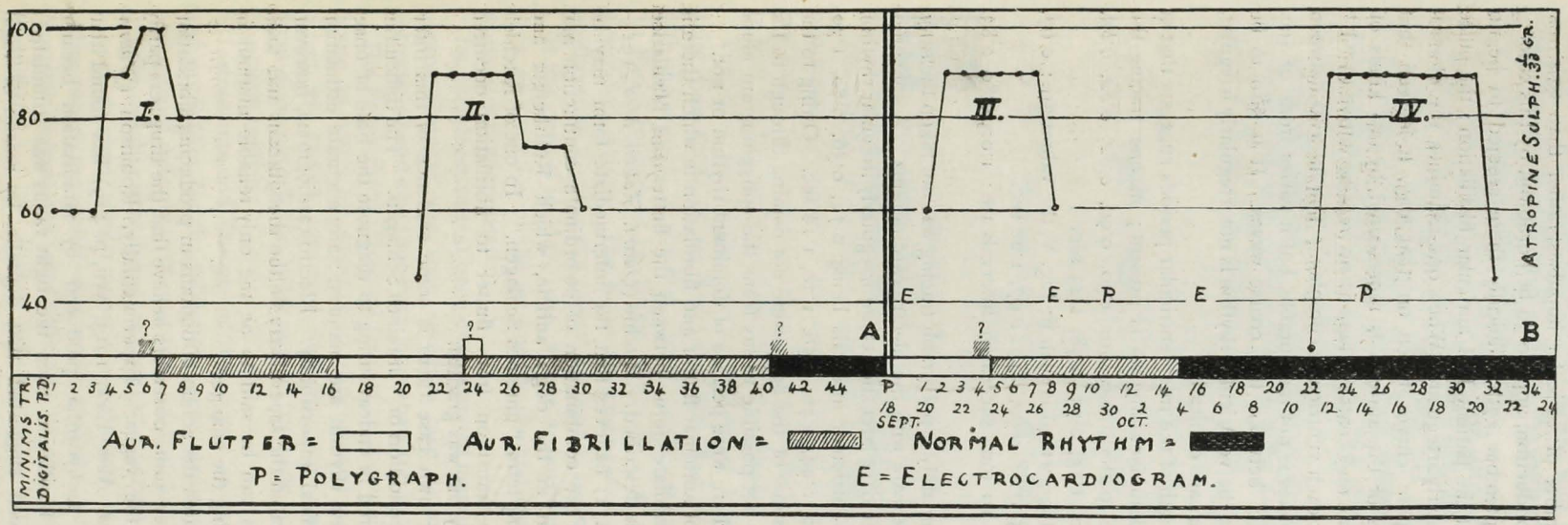
Failure to produce the normal rhythm the first time (A I) appears to have been due to the premature withdrawal of the drug after auricular fibrillation had occurred.

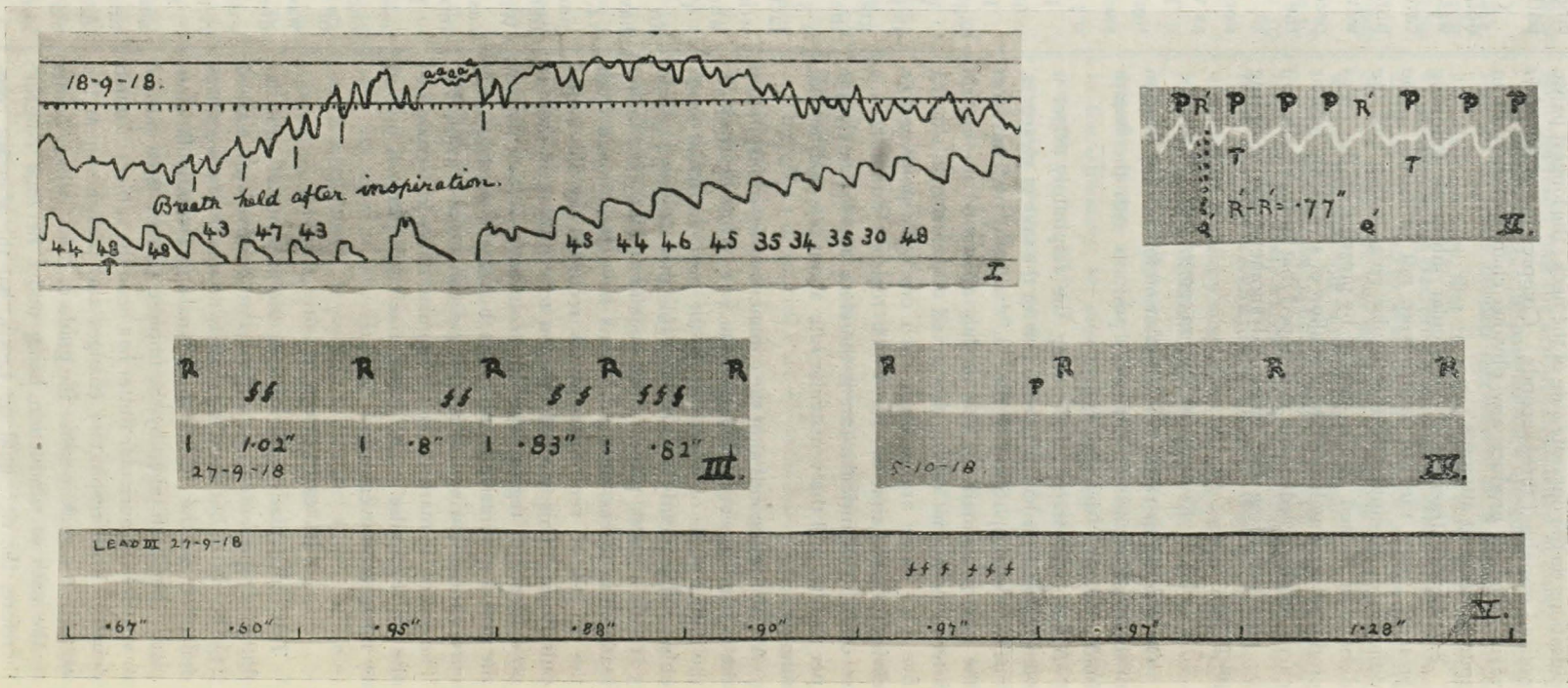
THE EFFECT OF ATROPINE SULPHATE.

On October 23rd, two days after the digitalis had been omitted, $\frac{1}{33}$ gr. atropine sulphate was given subcutaneously. The ventricular rate increased from 76 to 108 in 38 minutes. The time taken to reach the maximum rate was longer than had been experienced in other cases. Preliminary slowing was well marked, the pulse falling to 64 per minute in 13 minutes.

EFFECT OF PRESSURE UPON THE VAGI.

September 18th.—Compression of the *left* vagus in the neck sometimes resulted in ventricular inhibition as





evidenced by absence of the heart-sounds and carotid pulsations on the opposite side of the neck; the longest pause noticed was about three seconds. Compression of the *right* vagus failed to produce any obvious change of rhythm in spite of frequent attempts.

Satisfactory tracings of ventricular inhibition following pressure upon the *left* vagus were not procured. The difficulty of manipulating the jugular receiver-cup and the discomfort caused to the patient by pressure on the vagus produced too much movement to allow of a readable jugular curve being recorded, but it is hoped that further trials will be possible, using the string galvanometer for recording purposes.

Effect of Respirations.

On September 18th a deep inspiration followed by fixation of the chest in the full inspiratory position with the breath held produced "dropped beats."

A polygraph tracing illustrating the respiratory effect is seen in Fig. 1; it has been re-drawn for the sake of clearness.

The superimposition of the "a," "c" and "v" waves at the commencement of the tracing allows of no certain interpretation, but during the period of ventricular slowing five "a" waves are isolated, each one corresponding to a division of the time marker, which registers one-fifth of a second. The auricular rate is therefore approximately 300 per minute, and the ventricular rate about one-quarter that number.

About five seconds after the commencement of inspiration the rhythm appears to change from 4 : 1 to 8 : 1 heart-block. the higher grade of block lasting for two ventricular beats only. Subsequently it seems probable that varying 4 : 1 and 5 : 1 block takes place. The jugular tracing only being readable in places, the calculations have been made from the length of ventricular cycles recorded by the radial pulsations. This method is open to criticism as there is no evidence of regular auricular contractions other than at the period of ventricular inhibition, but electro-cardiographic curves the following day render the conclusions justifiable. The ordinates marked on the jugular curve correspond to the radial impulse. The radial tracing in places is marred by muscular movements.

Electro-cardiographic Curves.

The ventricular complex during the presence of auricular flutter is represented by a large electro-positive wave marked "Q" in Fig. II, but there is probably no relation between this deflection and the "Q" of the normal supra-ventricular complex. The path taken by the impulse passing from auricle to ventricle in auricular flutter has been the subject of much debate. Both respiratory changes and pressure upon the vagus in the neck increase the grade of block, which points to the path of conduction being under nervous control; therefore, the view held by Lewis, that the aberrant complex is due to increased junctional activity owing to the larger number of auricular impulses rather than to a new path of conduction, appears to be borne out by this case.

On September 27th, clinically there seemed to be no doubt that the patient had auricular fibrillation; the pulse was irregularly irregular. When one examines the electro-cardiographic curves taken on that day, it is seen that fibrillation of the auricles is represented by two kinds of waves—fine and coarse; there is no representative of "P" preceding each ventricular complex. The interval between the fine waves is not measurable, but it varies from ·08 sec. to ·12 sec. between the coarse waves. It is also to be noted that the ventricular rhythm is not irregularly irregular, as was the case clinically.

The length of the interventricular periods suggests that at times a dominant rhythm is present; in one tracing the successive periods measure 1·30, 0·90, *0·82*, *0·82*, *0·85*, 0·73, 0·80, 1·15, 0·73, 0·98, 1·43 sec.

In another, which is seen in Fig. V, the values are: 0·67, 0·60, 0·95, *0·88*, *0·90*, *0·97*, *0·97*, 1·28 sec.

In Fig. III four successive intervals are: 1·02, 0·80, 0·83, 0·82 sec.

Unfortunately a polygraph tracing was not taken the same day to compare with the electro-cardiograms. A sphygmogram three days later showed an irregularly irregular rhythm, the interventricular intervals being 0·72, 0·56, 0·70, 1·30, 1·52, 0·70, 0·94, 0·76, 0·56, 1·38, 1·16 sec. Owing to the fact that some of the beats were not coming through to the wrist it is not possible to say from the sphygmogram alone whether there were periods of dominant rhythm or not.

Cases of auricular flutter and fibrillation in which there is an intermediate form between the flutter and fibrillation have been described. Ritchie (*Quart. Journ. Med.*, 1913–14, vii, p. 1) believes that the intermediate form may be similar to the combination of co-ordinate contraction and fibrillation in the dog's auricle, which Rothberger and Winterberg term "unreines Schlagen." In one of Ritchie's cases the transition from flutter to fibrillation occurred repeatedly but was gradual.

In our own case there is some evidence of this intermediate condition or "unreines Schlagen." The difficulties encountered in endeavouring to diagnose the time of onset of the new rhythm are manifest; any accurate estimation was a clinical impossibility. Electro-cardiograms, however, demonstrated the true nature of the arrhythmia, and their exhibition can be said to be the only reliable method of determining the changes.

As regards the action of digitalis in producing fibrillation after flutter, some observers believe that the drug acts partly through the vagus. Experimentally, Robinson (*Journ. Exp. Med. New York*, 1913, xvii, p. 429) has found that auricular tachycardia produced by faradisation became auricular fibrillation when the right vagus was stimulated; it has been suggested that digitalis, by reason of vagal

stimulation, converts flutter to fibrillation in the same manner. This theory is not incompatible with the knowledge that the vast majority, if not all, the cases of auricular flutter are the result of a carditis.

In a letter received from the patient, dated April 28th, 1919, he states: "As far as I am able to judge my pulse beats regularly but often. . . . the bad attacks from which I used to suffer such agony have stopped. . . . I am practically in the same condition now as when I left the hospital."

I am greatly indebted to Dr. Drysdale for the privilege of describing this case, and to G. Bourne for permission to publish a *résumé* of his paper.

THE FACIAL HOSPITAL,

78, BROOK STREET, W. 1.

By R. C. ACKLAND, M.R.C.S., L.R.C.P., L.D.S.

EARLY in the war and partially as the outcome of visits to France it was apparent to the writer of this article that the trench warfare then existing would mean a large percentage of head and face wounds.

The surgery of wounds of the face was forthcoming, but treatment of wounds of the face involving fracture of the jaw called for the co-operation of the dental surgeon, who in turn needed the help of the dental mechanic.

The Hon. Sir Arthur Stanley, acting on behalf of the Joint Committee of the Red Cross and Order of St. John, with the consent of the War Office, established a Hospital for Facial Injuries at 78, Brook Street, W. 1, of which the writer had charge. The house selected needed practically no alteration to make it a capital hospital of 40 beds.

It was opened in May, 1916, first as an auxiliary to and then as a Section of the 1st London General Hospital, by whom it was administered.

Its usefulness was at once demonstrated inasmuch as the parent Hospital was soon asked to take its overflow of patients, who at one time were more than 100 in number.

The Brook Street Hospital soon after acquired a second house as hostel for some of its patients, and 24, Norfolk Street, was rapidly furnished and equipped (also by the Joint Committee), the total number of beds in the two Hospitals being 77.

Instruments and fittings for the theatre as well as tools and appliances for the laboratory were obtained at once and without difficulty. Requests to 83, Pall Mall, brought prompt results, this being in marked contrast to what happened when similar appeals were made to the War Office when the writer was working at the 1st London Hospital before the establishment of the Red Cross Hospital.

To procure an Albee Saw quickly Sir Arthur Stanley himself sent a cable to Mr. Pierpont Morgan in American with the result that the saw was dispatched at once.

In all about 500 in-patients were attended. The major number of these needed mechanism of the most accurate and delicate type, first to reduce deformity, and secondly to immobilise the fractured jaws. Finally dentures carrying artificial teeth had to be made in the major number of cases. Special apparatus was designed to replace the bony framework of the face and so restore its contour.

The aim of the splint proper was not only to secure union of the bony fragments but also the proper occlusion of the teeth for masticating purposes. Nearly £300 worth of old gold jewellery was collected and assayed to be used in making the different mechanism. Some of this was transferred to other centres of the same kind which subsequently sprang up. Instruments were designed, and made in the laboratory, for measuring degrees of trismus and the strength of the "bite." An electrically driven air pump supplying pressure to points opposite each of the three chairs enabled the V.A.D. staff to throw "wash" into sinuses and wounds. This apparatus was used after each meal and especially just before the patients went to bed as a matter of routine treatment.

Wounds of the interior of the mouth cavity were thus rapidly got under control and absorption brought to its minimum.

The splints in general were of cast silver covered by gold electrically deposited. All sorts of attachments in the way of springs, screws and wires were brought into use as the special need of the case demanded.

Messrs. Meyer, and Melzter of Great Portland Street, by the direction of the writer, made an electrically driven saw carried at the end of a flexible metal arm (a stronger copy of the ordinary dental drill arm).

Various patterns of saws, twin and single, burrs and drills could be used. A special feature was an auxiliary handpiece, which could be used in the left hand to help steady the hold of the right hand and so prevent the saw or saws "chattering" or "running" away.

This saw with the Albee and all the other surgical fittings and furniture of the Hospital have been transferred to St. Bartholomew's Hospital as a gift from the Joint Committee of the Red Cross and Order of St. John.

The following members of the Surgical Staff of St. Bartholomew's were kind enough to undertake the surgery needed: Mr. Gask, C.M.G., D.S.O., Mr. Girling Ball, Mr. Sydney Scott, and again Mr. Girling Ball, as in turn these gentlemen undertook service in the expeditionary forces.

On the Dental Staff of St. Bartholomew's Hospital, Dr. Fairbank, Mr. Huddart, Mr. Bruce Stevenson and the writer were at work throughout, except that the first-named was "called up" for service in the Navy.

About the surgery of this class of injury so much has been written to the JOURNAL and so much has been said at special demonstrations on the subject that the writer will do no more than state a few of his opinions as the outcome of over three and a-half years of observation and treatment of these cases.

The skin and soft tissues in which the lower jaw is suspended form a pouch which tends by gravity to become a trap for pus. Even when pendant drainage exists it is difficult to maintain. Pus around the ends of fractured bone causes more or less necrosis. It is this coalition of things rather than a poor blood-supply—which is claimed to be the causes by most text-books—that handicaps all surgery of these parts. Therefore cleanliness by means of a stream of wash forced into the wounds under pressure at frequent intervals proved to be a necessity. Temperatures came down, and the patients attended more regularly for this treatment because of the sense of well-being and comfort it invariably brought about. Carbolic acid solution of 1 : 60 to 1 : 80 used hot was found to be the most effective wash. Merely "swabbing" the mouth out failed to empty the pus and food out of the wounds, and liquids used as a mouth-wash failed for the same reason.

Stereoscopic radiography (taken as a matter of routine of all patients) proved a necessity, as of course one would expect.

Strips or fragments of alveolar process, with teeth embedded, to which the splint could be cemented so as to keep it in position, seem to act as scaffolding for new bone growth, although the piece or strip with teeth was itself thrown off later. The strictest cleanliness by syringing was all-essential in dealing with these fragments.

When the fracture was such that healing by splinting alone could bring about union, teeth at the fractured ends or in their vicinity "killed" by the original injury—(the radiograph could not tell one which were dead—would prevent union, and splints often had to come off and these renewed before union would take place on re-splinting.

Of these fractures which splinting alone would notheal because the gap caused by loss of bone was too great, grafting was resorted to. The earlier grafts were from bone taken from a rib; the next was a series taken from the tibia, and those later from the crest of the ilium. The last-named were the most successful, and gaps which at the beginning of the war it seemed hopeless to attempt to graft were tackled most successfully towards the end of the war.

Small shavings of bone, with pedicles of soft tissue cut by the saw from the vicinity of a medium-sized gap and sewn into the gap by means of the soft tissues, was a means of obtaining union in two cases operated upon by the writer. Of course the usual splinting of the fragments preceded the above operation.

Although the results obtained by plastic surgery were more spectacular, the real difficulty was generally to obtain union of the bony fragments and to obtain it so that the natural occlusion of the teeth was not lost. However, in a large number of cases respect for the teeth and their occlusion did not complicate matters, for the teeth were either absent or were so inferior in type that the patient was better off for masticating purposes when well-made artificial teeth were supplied later.

The first four in-patients consisted of two men from the Southern, one from the Western and one from the Northern Commands, all of whom had not been treated for fractured jaws. One, whose whole chin was blown away, was on his admittance into St. Bartholomew's in his *eighth* hospital, and two others, also temporarily admitted under Capt. Girling Ball, were in three or four hospitals previously. So that it will be seen that there was an urgent need for special jaw work seeing that these men had been wounded six months to eighteen months previously. It was chance that discovered these cases to the writer, and his reasonable deduction that there were other like cases led to the establishment of this special hospital, which supposition was justified, for many other untreated cases were sent there for treatment.

The Facial Hospital was in existence from May 1st, 1916, to June 12th, 1919. In addition to its 500 in-patients it had a large number of out-patients attending from the surrounding private hospitals in the vicinity.

THE DRESSER'S VADE MECUM.

(1) A dresser has position but no magnitude.

(2) The sleeves of an operating gown and the wrists of the gloves (as supplied to dressers), produced ever so far in either direction, will not meet.

(3) Let A and B be two dressers in the box at 9 a.m. (their firm being on duty and the other dressers being away for the week-end). Let X represent the number of patients outside. Then the time taken to finish the lot $= T = \frac{x}{2}$ minutes $=$ not $< 2\frac{1}{2}$ hours. Give a short account of sister's remarks to A and B when they arrive in the ward at 11.45 a.m. to do dressings.

(4) Let there be four dressers on a firm. Let that firm be on duty. Explain why the senior dresser only does one afternoon in the box. If not, why not!

(5) Explain the term "septic dresser." Is he more septic than the others? Is this possible?

(6) A junior house-surgeon is one who is somewhere else when wanted.

(7) A senior house-surgeon is one who allots cases to dressers at 12.30 on full day and at 1.30 tells you off for not writing notes on them. W.S.S.

STUDENTS' UNION.

LAWN TENNIS CLUB.

SENIOR INTER-HOSPITAL CUP WON BY THE HOSPITAL.

Any misgivings felt by the team in not having J. G. Johnstone present in this final against St. Thomas's Hospital were quickly dispelled when Urwick, McCall and Cody quickly defeated their opponents in the Singles, and Krige, Summers and Orchard had each won a set.

As it turned out the Hospital won nine matches straight off without the loss of a set, and thus secured the Cup. Scores:

Singles.—W. D. Urwick beat C. Nicory, 6–3, 6–2; C. F. Krige beat F. B. Hobbs, 6–3, 8–6; H. D. McCall beat G. H. Poole, 6–3, 6–2; H. Summers beat Dalais, 9–7, 6–4; W. E. Cody beat Humfreys, 6–1, 6–4; S. Orchard beat Hoschild, 6–2, 6–4.

Doubles.—C. F. Krige and H. D. McCall beat C. Nicory and G. H. Poole, 6–0, 6–3; W. D. Urwick and H. Summers beat F. B. Hobbs and Humfreys, 8–6, 6–4; W. E. Cody and S. Orchard beat Dalais and Hoschild, 6–1, 6–2.

The second team failed against Guy's in the final for the Junior Cup, the latter hospital putting up a team which was nearly as good as their first team.

It is expected that Johnstone, Urwick, Summers, Orchard and Cody will all be available next year, and therefore we may hope for another successful season.

Colours have been awarded to J. G. Johnstone, W. D. Urwick, C. F. Krige and H. D. McCall.

CORRESPONDENCE.

THE TREATMENT OF AMŒBIC DYSENTERY.

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

SIR,—I should like to reply to the sharp criticism aimed at me by Major Maxwell, R.A.M.C., on the subject of amœbic dysentery.

The treatment of dysentery by the so-called heroic doses of ipecacuanha is still upheld by so eminent an authority on tropical diseases as Sir Patrick Manson, so I consider myself in good company. To describe the method as "positively barbarous" is hardly tactful.

If Major Maxwell has never seen a patient upset by hypodermic injections of emetine he must have been very lucky, for it is a well-known fact that in a considerable proportion of cases it gives rise to diarrhœa, and, in a few, to degrees of peripheral neuritis characterised by feelings of weakness, sometimes amounting to paresis of the extremities and impairment of deglutition. As regards the D.A.H., an extraordinary large percentage of troops invalided with dysentery from Gallipoli and Mesopotamia have developed D.A.H., as many M.O.'s of my acquaintance have also noted, and we attributed this to the use (? abuse) of emetine.

I found that in making a rectal injection the patient was able to locate the fluid, therefore I consider the X-ray experiment suggested unnecessary. Dysenteric ulcers, it is true, may occur in the lower ileum, but they are most frequent in the cæcum and the flexures.

I did not mention dysenteric "carriers" and would never attempt to prove that they could be cured. It is curious that there should have been 1342 deaths from dysentery out of a total of 38,108 cases in the South African campaign, if "the dysenteric carrier is the only case that really causes any difficulty to the physician." Turning to more recent times, I am sure Major Maxwell cannot have seen many of the human wrecks that have returned and are returning from Mesopotamia suffering from chronic dysentery. The treatment of dysentery by emetine bismuth iodide was the first I tried out here and I consider it over-rated.

Apologising for encroaching upon so much of your valuable space.

I am, Sir,
Yours faithfully,
S. R. PRALL,
Capt. R.A.M.C.

BRITISH STATION HOSPITAL,
AHMEDNAGAR (DECCAN);
July 9th, 1919.

REVEWS.

PRACTICAL VACCINE TREATMENT. By R. W. ALLEN, M.A., M.D., B.S. (H. K. Lewis & Co., Ltd.) Pp. xii + 308. Price *7s. 6d.* net.

The author of this volume is a well-known advocate of vaccine therapy, his book on this subject having already run to a fourth edition. The present work is mainly written for the general practitioner, who can be forgiven if the present position of this enormously interesting but highly confusing branch of therapeutics is not quite clear to him. All phases of vaccine therapy are touched upon, the taking of the specimen, the preparation of the vaccine, its administration and the indications for same. Special chapters are devoted to diseases of the respiratory and circulatory systems, the skin and connective tissues, bones and joints, the intestinal tract, and the genito-urinary system. Quite the most interesting—and, from the point of view of the general practitioner, perhaps the most useful—part of the book is the concluding chapter, which deals with a series of questions on vaccine treatment which have been actually put to the author by medical men.

IRISH ETHNO-BOTANY AND THE EVOLUTION OF MEDICINE IN IRELAND. By MICHAEL P. MALONEY, M.B., Ch.B. (M. H. Gill & Son, Ltd.) Pp. 96. Price *4s. 6d.* net.

This little work aims at giving in outline the evolution of medicine in Ireland and at indicating the comprehensive characters of Irish ethno-botany. The first part comprises a list of the native medicinal Irish herbs; the second the evolution of medicine in Ireland. To the native medicinal herbs are attached their Irish names, and in some cases indications of their medicinal properties. The latter part of the book deals in a very sketchy way with the history of medicine in Ireland from Druidical to modern times, but we should be very sorry to regard it as a contribution to the evolution of medicine in that part of the world.

DISEASES OF WOMEN. By THOMAS G. STEVENS, M.D., F.R.C.S. (Hodder & Stoughton & Henry Frowde. London Medical Publications.) Pp. 431. Price *15s.* net.

We reviewed this volume when it was first published in 1912 and need only reiterate what we said on that occasion, namely, that it is probably one of the best books available on the subject from the point of view of the student.

The edition has now been reprinted, and in spite of rival works should still command a ready sale.

A SHORT PRACTICE OF MEDICINE. By ROBERT A. FLEMING, M.A., M.D., F.R.C.P.E., F.R.S.E. (J. & A. Churchill.) Third Edition. Pp. 675. Price *21s.* net.

For nearly two years the last edition of this work has been out of print, and we are glad to see this well-written and excellently arranged book making its reappearance. As the author says, there are many excellent text-books on medicine but few small-sized manuals. This is not to suggest that the volume under review is any way in the nature of a revision book: the essential details are given in every case, but such details as qualitative and quantitative testing of normal and abnormal constituents of urine and stomach contents are omitted, and pulse-tracings with their diagnostic significance have not been described.

It is rather to be regretted that in a book of this description no attempt has been made to group together clinical features in tabulated form. Such tables are most helpful for examination purposes.

The present volume contains some useful notes on trench fever and trench nephritis, and several new illustrations have been added to those in the previous edition.

We can with confidence recommend the book to our readers. It is larger than most manuals, it is smaller than most text-books, and should prove a valuable help to the student as well as of considerable service to the busy practitioner.

ESSENTIALS OF PHYSIOLOGY. By F. A. BAINBRIDGE and J. ACKWORTH MENZIES. (Longmans, Green & Co.) Third Edition. Pp. 484. Price 12*s.* 6*d.* net.

The first edition of this book was published in 1914, and the fact that a third volume is already being called for is sufficient evidence of its popularity. We do not think we should be far wrong in saying that it is probably the most-popular book on physiology which has been published during recent years. For examination purposes the book is admirable. Although small and compact, no essential details have been omitted, and while for the higher examinations larger volumes on the subject may have to be consulted, especially from the experimental side, the book may be relied upon as a sound working basis.

The present volume has been thoroughly revised and brought up to date, and now contains 179 illustrations. The sections dealing with the constitution of proteins and with the chemical changes accompanying muscular contraction have been re-written. The authors have also thought it advisable to re-write the section on the functions of the renal tubules.

EXAMINATIONS, ETC.

UNIVERSITY OF LONDON.

Examination for M.D. Degree, July, 1919.

Branch I. Medicine.—C. Cooke.

First Examination for Medical Degrees, July, 1919.

E. J. Blackaby, D. A. Brigg, R. K. Cannan, L. I. M. Castleden, R. S. Coldrey, F. S. Coleman, J. R. Collacott, E. R. Cullinan, J. Elgood. D. B. Fraser, F. H. K. Green, C. C. Hentschel, N. A. Jory, R. A. E. Klaber, N. E. Laurence,† J. Maxwell, H. V. Morlock, R. D. Reid,* A. J. D. Smith, H. B. White, L. A. Willmott.

* Awarded a mark of distinction in Inorganic Chemistry.

† Awarded a mark of distinction in Physics and in Biology.

Second Examination for Medical Degrees, August, 1919.

Part I.—J. R. Hamerton, R. H. Cooke, N. A. Jory, I. Kinsler, H. L. Oldershaw, C. M. Pearce, R. W. H. Tincker.

CONJOINT EXAMINATION BOARD.

First Examination, July, 1919.

Part I. Chemistry.—V. Barkin, G. Elliot, W. R. E. Harrison, B. A. J. Mayo, M. H. Samy, R. W. Savage, H. H. D. Sutherland.

Part II. Physics.—V. Barkin, G. Elliot, W. R. E. Harrison, C. de W. Kiteat, T. M. Marcuse, M. H. Samy, R. W. Savage, H. H. D. Sutherland, T. B. Thomas.

Part III. Elementary Biology.—V. Barkin, G. R. Nicholls, R. W. Savage.

Part IV. Practical Pharmacy.—F. Asker, S. J. Davies, E. Savage, H. C. M. Williams.

Second Examination, June, 1919.

Anatomy and Physiology.—N. L. Capener, B. J. Hallowes.

DIPLOMA IN PUBLIC HEALTH.

The Diploma in Public Health was conferred upon C. D. Day, and Major H. Falk, I.M.S.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

The following having passed the required examination was admitted a Member: A. C. Roxburgh.

LONDON SCHOOL OF TROPICAL MEDICINE.

The following candidate was successful at the examination held at the end of the sixth session (May–July, 1919): Capt. W. C. Spackman, I.M.S.

APPOINTMENTS.

ALLEN, Temp. Major W. G. E., R.A.M.C. (retired), M.R.C.S., L.R.C.P, appointed to Board of Assessors, Ministry of Pensions, Burton Court, Chelsea.

BUTTERY, H. R., M.R.C.S., L.R.C.P., appointed House Physician at the Royal Chest Hospital, City Road.

COOMBS, H. M. McC., M.R.C.S., L.R.C.P., appointed Certifying Surgeon under the Factory and Workshop Acts for the Bedford District of the County of Bedford.

FORSYTH, J. A. CAIRNS, M.Sc., M.B., F.R.C.S., appointed Surgeon to the French Hospital, London.

LISTER, Major A. E. J., I.M.S., M.B., B.S.(Lond.), F.R.C.S., appointed an Honorary Surgeon to H.E. the Viceroy and Governor-General of India.

QUINE, A. E., M.B, Ch.B.(Vict., Manchester), F.R.C.S.Eng., appointed Joint Venereal Diseases Medical Officer for the Cumberland and Carlisle City County Councils.

RAMSAY, J., O.B.E., M.D.(Lond.), appointed Medical Referee, Ministry of Pensions, Blackburn area.

STRONG, R. H., M.R.C.S., L.R.C.P.(Edin.), appointed Assistant School Medical Officer to the Edmonton Education Committee.

WOODMAN, MUSGRAVE, M.S.(Lond.), F.R.C.S.(Eng.), appointed Hon. Aural Surgeon and Laryngologist, General Hospital, Birmingham.

WYLLYS, WILLIAM, M.R.C.S., L.R.C.P., L.S.A., appointed Honorary Ophthalmic Surgeon to the Great Yarmouth General Hospital.

CHANGES OF ADDRESS.

ALLEN, Temp. Major W. G. E., R.A.M.C. (retired), 28, Westbourne Gardens, Folkestone.

ARCHER, CHARLES W., 7. North Park Road, Harrogate.

ARMSTRONG, R. R., 28, Wimpole Street, W. 1.

BOURKE, J. B., Market Street, Crewkerne.

BURKE, Major G. T., I.M.S., 48th Indian General Hospital, Army of the Black Sea, Constantinople.

CONNOR, Lt.-Col. F. P., D.S.O., I.M.S., 2, Upper Wood Street, Calcutta.

GREY, Capt. H. MARTIN, R.A.M.C., Officers' Mess, Delhi Barracks, Tidworth, Salisbury Plain.

HARTILL, S., Bucklands, East Cowes.

HATTERSLEY, Capt. S. M., R.A.M.C., Pink House, Tiguè, Malta.

LAVAN, L. T., 5, Grosvenor Street, W. 1.

MANLOVE, J. E., 10, Wyndham Place, W. 1.

MAXWELL, Major J. L., R.A.M.C., Shinro, Tainan, Formosa.

POWELL, J. C., 22, Welbeck Street, Cavendish Square, W. 1.

SALE, J. C., Weeumbah, Longreach, Queensland, Australia.

TRIPP, C. L. H., 11, East Grove Road, St. Leonards, Exeter.

WILLIAMS, CYRIL, Ardmore, New Place, New Town, Uckfield, Sussex.

BIRTHS.

HILL.—On August 7th, at Dalestead, Caterham Valley, Surrey, the wife of Fred T. Hill, M.R.C.S., L.R.C.P., of a son (Anthony).

KEMP.—On July 24th, at Caversham, Lemsford Road, St. Albans, the wife of C. Gordon Kemp, M.D., of a daughter.

KEYNES.—On August 14th, at Grove House, Hollywood Road, S.W., the wife of Geoffrey Keynes, M.D., of a son.

TURTON.—On July 30th, at 21, Brunswick Place, Hove, the wife of J. R. H. Turton, M.B., B.S., F.R.C.S., of a daughter.

MARRIAGES.

COWAN—SNELL.—On August 23rd, at Brixton Independent Church, S.W., Capt. David John Cowan, 5th Bn. Connaught Rangers, only son of Mr. and Mrs. E. W. Cowan, to Katharine Mary, younger daughter of Rev. Bernard J. Snell.

LOWE—WALTERS.—At Inkpen, Hungerford, on July 30th, by the Rev. H. D. Butler, Rector, Major Godfrey J. R. Lowe, R.A.M.C. (T.), Registrar, 4th Northern General Hospital, Lincoln, to Miss Olive Walters, R.R.C. (late T.F.N.S.), only daughter of Mr. and Mrs. J. W. Walters, of Sadlers, Inkpen.

VON BERGEN—ALLEN.—On August 19th, at St. John's, Limehouse Fields, Carl W. von Bergen, M.D., of Devon House, Leatherhead, to Mary Barbara Satow, only daughter of Edward Satow Allen, of Crampshaw Cottage, Ashtead.

DEATHS.

DRAGE.—On August 14th, 1919, at North Place, Hatfield, Lovell Drage, M.D.

POWER.—Formerly reported wounded and missing during the second battle of Ypres, now known to have died in German hands on May 9th, 1915, Lieut. George Henry Fosbroke Power, 6th Battn. Middlesex Regiment, Commoner of New College, Oxford, and President of the Oxford University Fencing Club, aged 21, the dearly loved younger son of D'Arcy and Eleanor Power.

WILKS.—On June 11th, 1919, at his residence, Ashford, Kent, George Wilks, M.C.(Cantab.), M.R.C.S., L.S.A.