syphilitic cases were congenital, without interstitial keratitis.

Investigation showed that an iritis may be undoubtedly syphilitic and yet present a local appearance resembling the so-called "rheumatic" type.

Syphilitic iritis may also be associated with severe pain.

II. "*Rheumatic.*"

Careful analysis of the so-called "rheumatic" cases failed to show positive evidence of true rheumatism. In one case there was, however, some erythema nodosum combined with a very chronic synovitis of the knees, and in another a past history of chorea, and synovitis of the knees with the iritis. There was no evidence of morbus cordis. No case occurred *in the course of* rheumatic fever, and where iritis does so occur gonorrhoea or osteo-arthritis should be suspected.

I am convinced that there is undoubtedly a very striking connexion between diseases of the iris and diseases of the joints, and that the etiology of iritis is much the same as that of joint disease.

It would, therefore, seem possible that an iritis of rheumatic origin *may* occur, but examination usually shows that in cases so diagnosed the synovitis is of a chronic type, especially in the knees, and most probably of the nature of osteo-arthritis.

III. *Gonorrhoea.*

The great importance of gonorrhea as a cause of iritis has only been emphasized of late years. I found in this analysis, which was made in 1901, that there was evidence that from 15 to 8.1 per cent. of all cases were due to this cause according as we include the less certain cases or not.

This type is especially prone to relapse. Relapse may occur soon after or long after the original attack, and may also occur after dilatation of a stricture.

All the patients were men.

IV. *Toxaemic.*

This group includes cases occurring in association with various diseases—for example, influenza (iritis a sequel in two instances), pyaemia, chronic nephritis, mumps, diphtheria, diabetes, bronchitis, tubercle, etc.

V. *Gout.*

Iritis certainly occurs in gouty subjects, and possibly 1 per cent. of cases may be due to gout.

VI. *Osteo-arthritis.*

Iritis certainly occurs with typical osteo-arthritis, and it is very probable that this group is really much more important than the so-called "rheumatic" group. From the notes, however, I could not find definite evidence that it accounted for more than 1 per cent. of all cases.

VII. *Obscure.*

The obscure cases were most common in women, and constitute 10.6 per cent. of all cases. Setting aside the possibility of syphilis and gonorrhoea, of which no trace of evidence was present, the ascertainable factors in this group could only be regarded as of secondary importance—namely, exposure to cold, starvation, exhaustion from hyperlactation, alcoholism, and errors of refraction.

Addendum.

Exposure to cold seems to be of some importance, the majority of admissions in non-venereal cases being in February. Some of the obscure cases may have been due to sepsis or tubercle.

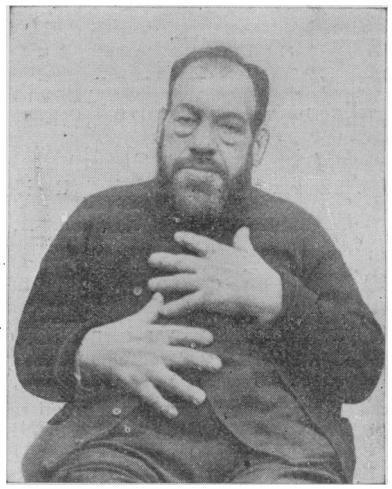
The dentist was called in nine times in all the cases, and in three of these removal of carious teeth from the upper jaw on the same side as the iritis was of decided benefit. One of these was a syphilitic case, and the other two "rheumatic." It is interesting to note that Mr. Butler regards tubercle as a common cause of iritis. In the St. Bartholomew's cases only one was noted, and that was of a dubious kind.

Diagnosis of tuberculous disease generally has, of course, been much improved since 1900.

Memoranda:
MEDICAL, SURGICAL, OBSTETRICAL.

FURTHER NOTE ON A CASE OF ACROMEGALY.

DURING the last ten years the man whose case was reported in the BRITISH MEDICAL JOURNAL of February 2nd, 1901, p. 270, has had fairly good health, although very gradually becoming weaker, so that he can now only crawl about with the aid of two sticks. He has become bent, with marked cervico-dorsal kyphosis. He eats well, and sleeps too well. He is losing weight, and has sunk from 5 ft. 10 in. high to 5 ft. 7¾ in. The head measurements are now: Circumference, 25½ in.; from forehead to chin, 11 in.; from nape of neck to chin, over nose, 25 in.; the nose measures 2¾ in., the right ear 3½ in., and the left 3 in.; the lips when in a state of repose are ¾ in. apart; the lower jaw protrudes 1½ in. in front of the upper. The teeth are mostly loose and are fast falling out. The upper portion of each ear tends to get flattened, hard, and board-like, especially on the right side. He keeps his mouth open owing to difficulty in breathing through the nose. The eyelids are normal, but under each lower lid is a semilunar fold of tissue. The two hands measure the same, and each is 6 in. across the root of the thumb and 5 in. across the root of the fingers. When closed the hand measures 15¼ in. round. The length of the middle (the longest) finger is only 3½ in. The pomum Adami is absent. Tongue not much affected. The lower lip is much enlarged and pendulous. There is no thirst and no polyuria. He is decidedly anaemic-looking, but without any yellow tinge. The protruding abdomen is tending to recede. He suffers from haemorrhoids.



The photograph was kindly taken for me by Mr. Kirby, of the West Ham Asylum.

Chadwell Heath. T. REUELL ATKINSON.

ANTILYTIC SERUM IN THE TREATMENT OF CHRONIC GASTRIC AND DUODENAL ULCERATION.

THOUGH attention was drawn to the use of antilytic serum in the treatment of chronic gastric and duodenal ulceration by articles in the JOURNAL in 1908 and 1910, it does not seem to have become widely recognized. I therefore think that it may be of interest to quote a case recently under my care, in which, as far as it is possible to tell in an individual case, the serum was the direct means of saving life.

A man, aged 63, suffered some eight years ago from symptoms of duodenal ulcer; they passed away under treatment. He remained well until five months ago, when he had an attack of gastric influenza, accompanied by acute vomiting, which lasted twenty-seven hours. At the end of this time he vomited a considerable quantity of blood. Haemorrhage continued at intervals for three weeks, when he was seen by both Dr. Goodhart and Sir Thomas Barlow, who confirmed the diagnosis of haemorrhage from an old duodenal ulcer. The haemorrhage then became constant, and continued so for another three weeks. Every drug and other treatment was tried, but with no effect. When the patient was apparently moribund, I started the antilytic serum (prepared by Allen and Hanburys), giving it by the mouth in full doses. Within a few hours the haemorrhage completely ceased, and has

not recurred, and the patient made an uninterrupted recovery.

Of course it may be argued that little can be drawn from the result in a single case, but in the minds of those who were watching this one, there is no doubt that the cessation of the haemorrhage and the subsequent recovery were due to the serum. I think that this preparation is well worth an extended trial in these cases. The only drawback is the price, which is high, and therefore puts it out of the reach of the poor.

Woking. R. THORNE THORNE.

Reports
ON
MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

BIRMINGHAM CITY INFIRMARY.

CASE OF IDIOPATHIC DILATATION OF THE COLON (HIRSCHSPRUNG'S DISEASE).

(Under the care of Dr. T. SYDNEY SHORT.)

[Reported by GAVIN S. BROWN, M.B., Ch.B.Edin., Resident Medical Officer.]

THE patient in the following case, a well-nourished and intelligent child, aged 3 years, was admitted on November 9th, 1910, with an enormously distended abdomen and wasting of the left leg.

State on Examination.—The abdomen was seen to be distended uniformly, and moved freely with respiration. A few dilated veins were seen on the surface, principally around the region of the umbilicus. Visible peristalsis was present, especially centrally, and the "ladder pattern" was well seen. The circumference at a point 3 in. above the umbilicus=24½ in. and at the umbilicus=21 in., the navel being markedly protruded. The surface of the belly felt doughy, and somewhat hard generally. It was tympanitic all over, and showed no sign of fluid in the peritoneal cavity or of enlargement of any organ. The left leg was wasted, with marked general muscular atrophy, and flail-like movement of the thigh on the hip. The lungs seemed hampered by the abdominal distension, and the respirations = 28. Beyond slight general bronchitis the lungs and heart appeared normal. The urine showed a haze of albumen and specific gravity of 1024; from 10 to 20 oz. were passed daily.

Progress and Result.—Repeated injections given by a long tube, high up, and aperients failed to give more than temporary relief; the motions thus produced were hard, lumpy, and extremely foul. On the 25th she passed much loose stool, smelling badly, and vomited once. The temperature rose to 100°, and she died somewhat suddenly the same evening.

The mother stated that the child was healthy up to 4 months old, though always constipated and requiring aperients. The belly was full from birth. At 4 months convulsions occurred, and continued at intervals up to 7 months. At this time she noticed the loss of power in the left leg, and was told it was infantile paralysis. The distension and the constipation both increased. There seemed to be loss of power to evacuate, and often seven days would pass without relief. This continued to the time of admission.

Autopsy.—On opening the abdomen the whole of the large intestine was seen to be greatly distended. Although the caecum and ascending colon shared in this, the principal increase in size was due to an enlargement between the hepatic and sigmoid flexures. There was slight comparative narrowing at the end of the descending colon. Below this again the distension was enormous, and the gut measured 7 in. in circumference. The muscular coats of the whole of the large gut were greatly thickened; the mucous coat looked smooth and attenuated, showing no sign of past or present ulceration; and the lumen of the tube was blocked with horribly offensive faecal matter. The rectum contained faeces of the same character, and the small intestine was relaxed and empty. The kidneys were congested with slightly adherent capsules, but the other organs showed no special abnormal condition.

Remarks by Dr. Short.—The diagnosis in this case at first seemed to lie between tuberculous peritonitis, enlargement of some abdominal organ, and congenital enlargement of the colon. But no enlargement of any organ was found, and the marked peristaltic action associated with such enormous distension and constipation, with good general nutrition, without rise of temperature, seemed to point to congenital enlargement of the colon, or Hirschsprung's disease.

The autopsy justified this opinion.

Reports of Societies.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Wednesday, May 3rd, 1911.

Dr. BYROM BRAMWELL, President, in the Chair.

Enucleation of the Faucial Tonsils.

DR. J. S. FRASER, after describing the anatomy of the tonsils, said their removal was indicated in chronic hypertrophy. The procedure depended on whether the enlarged tonsils were submerged or pedunculated. If the latter the guillotine was as efficient and simpler, and therefore superior. But in submerged or sessile tonsils, enucleation alone enabled a thorough removal. After applying ½ per cent. cocaine solution, with a little adrenalin added, the tonsil was fixed and pulled inwards by vulsellum forceps, with curved scissors the mucous membrane was snipped through, beginning below and continuing up to the upper pole, keeping close to the anterior pillar. It was then possible to remove the tonsil with capsule entire from its bed. Some difficulties were: Friability of the tonsil; peritonsillar adhesions; primary haemorrhage, best treated by local application of hydrogen peroxide or turpentine, or, these failing, by use of artery forceps; reactionary haemorrhage had occurred in 2 out of his 80 cases. He had also 2 cases of cocaine poisoning, in which there was temporary faintness, gasping dyspnoea, and pallor. The after-treatment was the use for several days of an antiseptic gargle (phenyl-sodic), or of formalin lozenges, with soft foods. There was usually pain in swallowing for four or five days, but no subsequent interference with talking or swallowing. Lantern slides were shown illustrating the structure of the enlarged tonsils and the successive steps of the enucleation operation. Dr. LOGAN TURNER said it was not easy to say when a tonsil was deficient in function. In his opinion, the larger the tonsil the less harmful it was. Statistics as to the percentage of tuberculous tonsils varied, but the highest authoritative figure, about 5 per cent., was not a large one. For children he preferred the guillotine, but in adults, in recurrent quinsy and septic condition of the crypts, the more thorough removal by enucleation was superior. He did not use cocaine, but a 2–5 per cent. solution of novocain with adrenalin. If the enucleation was thorough, bleeding seldom occurred. In his experience there was often much pain after the operation, and for this he used insufflations of orthoform and hot fomentations on the neck. Dr. ELLIOT (U.S.A.) said that in America the snare was used by the majority of operators in enucleation, and in his own experience was decidedly superior. Dr. PORTER had not found enucleation an easy operation, the difficulty being to hit the proper depth of the scissor incisions, which must not go through the capsule. He agreed that for children the guillotine was superior. Mr. STRUTHERS considered enucleation a severe operation, often attended with bleeding. As to local anaesthetics, from his experience in other operations, he would recommend weaker solutions, novocain ½ per cent., or 1 in 500 solution of cocaine. Dr. LITHGOW and Mr. DOWDEN also spoke, and Dr. FRASER replied.

Diagnosis of Urinary Calculi by X Rays.

Dr. EDMUND PRICE summarized the results of 143 examinations for urinary calculi; 103 were negative, while of the positive results operation was performed in 23 cases, no stone being found in two of these. The presence or absence of stone in the urinary tract by this method of examination was certain, if the following conditions were fulfilled. These were—a good technique, a complete examination on both sides from bladder to kidney on the morning of operation; and actual incision of the kidney, if it were indicated, mere palpation being not sufficient to exclude calculus. Confusion in diagnosis might be caused by phleboliths, calcareous glands, and the stumps of excised appendices

THE PLAGUE.

PREVALENCE OF THE DISEASE.

INDIA.

DURING January, February, and March, 1911, the deaths from plague in India numbered respectively 77,921, 88,498, and 166,135, a grand total of 332,554.

During the three months the deaths from plague were distributed in the various provinces of India as follows:

Bombay Presidency (6,364 January, 6,703 February, 5,995 March), 19,062; Bengal (8,446, 11,863, and 21,807), 42,116; United Provinces (39,794, 43,508, and 95,884), 179,186; Rajputana (2,647, 3,326, and 5,012), 10,985; Punjab (8,028, 13,064, and 27,166), 48,258; North-West Frontier Province (19, 8, and 31), 58; Kashmir (43, 27, and 73), 143; Central Provinces (5,067, 5,541, and 5,245), 15,853; Central India (2,404, 924, and 2,115), 5,443; Hyderabad State (1,032, 784, and 699), 2,515; Mysore State (1,386, 656, and 158), 2,200; Madras Presidency (1,594, 1,050, and 784), 3,428; Burma (1,096, 1,044, and 866), 3,006.

It will be seen that, as in past years, the United Provinces head the list in the mortality returns for plague; in the month of March the Provinces returned more deaths from plague than all the rest of India—namely, 95,884 to 70,251 to the whole of the rest of India. In every month also the United Provinces lead. Some of the peculiar features of this continued epidemic are: First, that Eastern Bengal and Assam have had merely isolated cases of plague from time to time, and that the cases in the city of Madras have also been mostly sporadic or imported; secondly, the disease recurs with the maximum of virility in the same districts year after year. It is also noticeable that the disease reappears about the same time and decreases in virulence about the same period each year, the months of March and April being the periods of maximum recrudescence.

CHINA.

In Manchuria the epidemic of pneumonic plague is reported to be wholly at an end. The epidemic seems to have expended itself in a northerly direction, and to have reached Blagovestchensk and the Amur river about March 1st. The Chinese settled on the right bank of the Amur river entertained a hostile attitude towards the Russian authorities, and objected to the quarantine regulations imposed by the Russians. It is reported that of 500 soldiers sent by the Chinese Government against the Chunchuses all died. The troops started from Kwangchengtsze, and appear to have carried the disease with them. The belief that the marmot—the tarbagan, as it is called locally—is the animal by which plague is kept alive in Mongolia and its immediate borders is gaining strength, and has been supported in recent years by Clemow and Cantlie. Although plague has subsided for the present in Northern China, there seems, unfortunately, every probability that it will reappear in October of this year, as it has done for the past sixty years, but never with the virulence shown in the winter of 1910–11.

HONG KONG.

After a six months' immunity from plague 1 case of plague was reported in Hong Kong on April 24th, 1911. The last week in April was the period during which plague has recurred yearly ever since 1894, when plague appeared in the colony for the first time.

EGYPT.

Plague prevailed in Assiout, Assouan, Gizeh, Kana, Minieh, and Menouf during January. During the month 59 cases were reported and 26 deaths from the disease.

Universities and Colleges.

UNIVERSITY OF EDINBURGH.

GENERAL COUNCIL.

Report on Clinical Teaching.

AT the statutory half-yearly meeting of the General Council of the University of Edinburgh, held on May 3rd, the most interesting business was the report of the subcommittee on the mutual relations between the bodies concerned in medical education in Edinburgh. The committee had restricted its inquiries to clinical teaching which most required attention.

Dr. Norman Walker, in submitting the report, stated that in the opinion of the committee the most pressing reform was a better-ordered arrangement of clinical classes, and believed that this could only be effected by the complete fusion of the intramural and extramural sections of the hospital staff. A beginning had been made by the appointment of all the surgeons, save one, as university lecturers and examiners in clinical surgery, but the next step of restricting the numbers attending one clinic had still to be taken. The report contained the following passages:

"Next would come the formation of a Board of Studies in each subject, which would agree upon broad lines of teaching, the fullest liberty inside these being allowed to each individual teacher. It would, however, be necessary for the teachers to agree on the conditions under which certificates of attendance should be granted to students, and to suggest to the Senatus the maximum number who would be permitted to attend one clinique.

"So much more attention is now given to individual teaching that the committee think the fees ought to be increased, and the perpetual ticket abolished in clinical medicine, as it has been in clinical surgery. They think the fee for each of these classes ought to be three guineas per term.

"There are two other hospitals which might well be brought into more intimate connexion with university teaching. The Royal Hospital for Sick Children is utilized in connexion with the class of diseases of children, and it is understood that the university contemplates making attendance on that class compulsory. The other hospital referred to is that of Leith. It seems unfortunate that a modern hospital adequately equipped and so capably staffed as is that institution, should not be similarly utilized for teaching purposes. Its distance from the school is, of course, a drawback; but if the physicians and surgeons of that institution were university lecturers and examiners, it might be of use in relieving the congestion from which the Royal Infirmary sometimes suffers.

"The department of pathology in the Edinburgh Infirmary has very little connexion with the university. One of the assistants to the chair usually happens to be one of the assistant pathologists; but so long as the professor of pathology is a professor of clinical medicine it is useless to suggest any further connexion between the chair and the *post-mortem* department. When a new professor is appointed, he certainly ought to be connected officially with the *post-mortem* department of the infirmary.

"Of obstetrics one can only say that, so long as there is no residency attached to the Maternity Hospital, so long will the Edinburgh students continue to go elsewhere for their instruction, and the committee are glad to learn that there is a prospect of a residency being established. Co-operation among all the obstetric charities in Edinburgh will provide sufficient material. Cliniques given at a definite hour in the afternoon are no doubt useful, but they cannot take the place of the practical instruction which is given to resident students.

"The dispensaries of Edinburgh are a characteristic and unique feature of the school. They perpetuate the useful side of the old apprenticeship system, and a capable dispensary physician has an opportunity of a closer intimacy with his students than almost any other teacher. It is not easy to see how the university could bring about any closer relationship with these institutions, except that it might enforce upon them the restriction in point of numbers which it is to be hoped it will shortly enforce in the Infirmary, and might perhaps require evidence that something in the way of reporting on cases had been insisted upon.

"As Professor Woodhead in his report[1] says, it is evident that no scheme can be carried out without the co-operation of the managers of the various institutions concerned, and with his suggestion of a conference of representatives of these various bodies the committee cordially agree."

Dr. James Ritchie seconded, and the resolution was adopted.

[1] Note on Clinical Teaching, appended to the Report of the Treasury Committee on Scottish Universities.

Medical News.

DR. BYROM BRAMWELL will occupy the chair at the dinner to be given on the occasion of the joint visit to Harrogate of the Edinburgh University Clubs on May 20th, in place of Sir William Turner, who is unavoidably prevented from being present.

THE South African Civil Surgeons' dinner will take place at the Criterion Restaurant on Thursday, June 1st, and not at the Imperial Restaurant, as previously announced. Further particulars can be obtained from Mr. C. Gordon Watson, 123, Harley Street, W.

A GENERAL meeting of the Metropolitan Police Surgeons' Association took place in the Council Room of the British Medical Association, 429, Strand, on May 4th, when sixty members were present. Dr. Frederick J. Smith gave a demonstration on poisons and their *post-mortem* appearances, and also opened a discussion on police surgeons' difficulties and the way out of them. Many of the members took part in the discussion and related their experiences of police work.

THE Samuel Hyde Memorial Lectures to the Section of Balneology and Climatology of the Royal Society of Medicine will be delivered by Dr. R. Fortescue Fox on May 15th, 17th, and 19th, at 5 p.m. on each day; the subject selected is medical hydrology, the science of water and of waters, with a special plea for its practice and teaching in Britain. The chair will be taken by Sir Hermann Weber, Sir Dyce Duckworth, and Dr. Theodore Williams on the three days respectively. The lectures are in memory of Dr. Samuel Hyde, the founder of the British Balneological and Climatological Society.

The funeral took place at Fareham on April 29th, and his popularity was manifested by a great assembly of old friends of every rank, who crowded the parish church and followed to his last resting place.

Mr. George Case was twice married, and leaves a widow, four sons, and one daughter, and now in their great sorrow they possess the consolation of a sincere and universal sympathy. Mr. Hugh Case, the eldest son, who has been associated in practice with his father, will enter at once on new responsibilities.

ERNEST RICHARD EVANS, L.R.C.P., M.R.C.S.,

CONSULTING MEDICAL OFFICER, HERTFORD GENERAL INFIRMARY.

THIS popular and deeply-respected practitioner died on Thursday, May 4th, at his residence in Hertford, where he had been in practice from the early Seventies until the end of 1909, when he underwent amputation of one leg. He made a good recovery, and was able to go about in an armchair until a week before his death. He was the son of Dr. R. D. J. Evans of Hertford, and studied at St. Bartholomew's Hospital. In 1868–9 he filled the office of House-Surgeon to Mr. Luther Holden with great distinction. He had already acquired practical experience of his science and art in assisting his father, and hence was a most satisfactory under officer to his chief, and an excellent superintendent of his dressers. Several of them afterwards became medical officers of hospitals, and duly recognized how much they owed to him, none more so than Mr. W. J. Walsham, late surgeon to St. Bartholomew's, who was fated to die before him. After serving as House-Physician, Mr. Evans quitted Bartholomew's, and, wishing to gain more experience of hospital work, he applied for the appointment of Resident Medical Officer to the Evelina Hospital for Sick Children, then just opened, and was elected, being the first to hold that post. He became a Life Governor of St. Bartholomew's Hospital, which he frequently visited.

As a citizen of Hertford he was very public-spirited, taking an active part in the management of several charitable institutions. After a long tenure of office he retired in 1904 from his appointment as Honorary Medical Officer to the Hertford County Hospital. On this occasion he was presented with a valuable gold watch, Mrs. Evans, his wife, receiving a handsome silver rose bowl. That lady, whom Mr. Evans married in 1874, is the daughter of Mr. Benjamin Young of Mangrove Hall, Hertford, and survives him. They had two sons and a daughter. The eldest son, the Rev. Harry Evans, was one of his father's constant attendants from the time his illness began in 1909.

It is with much regret that we record the death of Mr. E. W. PARRY, which took place at Brisbane on January 27th at the early age of 29. He was the eldest son of the late Mr. Robert Parry of Earl's Court. He was educated at University College, Bangor, where he obtained an entrance scholarship, and at St. Thomas's Hospital, London, where he gained various distinctions and obtained the diplomas of M.R.C.S. and L.R.C.P. in 1904. Soon afterwards he was appointed Obstetric House Physician, and, later, Casualty Assistant at St. Thomas's, and it was whilst holding this appointment that the first symptoms of the disease which eventually carried him away made its first appearance. Under suitable treatment he improved a good deal, and in 1907 he felt strong enough to resume work and became House-Surgeon to the Bridgwater Hospital, where he remained for twelve months. At the end of this time he took the degrees of M.B., B.S.Lond., and soon entered into partnership with Dr. Brockway at Brisbane, where he made a large number of friends and was very successful in practice. He was of a modest and retiring disposition and was essentially devoted to his profession. Only those who knew him intimately could appreciate the nobility of his character and the deep sense of duty which actuated all his doings. He has died on the threshold of a life full of promise, much to the regret of all his friends, and the greatest sympathy is felt for his widowed mother in her bereavement.

DEATHS IN THE PROFESSION ABROAD.—Among the members of the medical profession in foreign countries who have recently died are Dr. L. Russ, Professor of Clinical Medicine at Jassy; Dr. W. N. Gagarin, a well-known ophthalmologist, of St. Petersburg; Dr. Beniamino Sadun, sometime Professor of Forensic Medicine and Psychiatry in the University of Pisa, aged 93; Dr. Oliver, Associate Clinical Professor of Ophthalmology in the Women's Medical College, Philadelphia, aged 57; Dr. W. F. Sprimon, of Moscow, founder and for many years editor of the Russian medical journal *Medizinskoe Obozrenie*; Professor Manz, Emeritus Director of the Eye Clinic of the University of Freiburg, aged 78; Dr. C. Stedman Bull, the well-known ophthalmologist of New York, aged 76; Dr. Leartus Connor, Professor of Physiology and Ophthalmology in the Detroit Medical College, aged 68; Dr. Botscharoff, Lecturer on Surgery in the Army Medical Academy of St. Petersburg; and Dr. Maegeli-Akerblom, of Geneva, well known by his writings on subjects of medical history.

Public Health AND POOR LAW MEDICAL SERVICES.

APPOINTMENT OF MEMBERS OF BOROUGH AND OTHER COUNCILS TO PAID OFFICES.

THE Local Government Board in England has issued the following circular to the councils of boroughs, urban districts, and rural districts:

"I am directed by the Local Government Board to state that they have had under consideration the question of the appointment to paid offices under town councils and urban and rural district councils of persons who are or have been members of those councils.

"Representations on this subject have been addressed to the Board from time to time, and they have been reminded of the rule made by the Registrar-General with regard to the office of registrar. The Royal Commission on the Poor Laws and Relief of Distress referred to that rule with approval, and have recommended that 'a local authority should not be allowed to appoint an ex-member as a paid officer unless he or she has ceased to be a member of the local authority for a period of, say, twelve months before appointment.'

"The Board are in agreement with this view, and they feel assured that councils generally recognize the impropriety of appointing to paid offices persons who are or have recently been members of their own body.

"The Board, therefore, think it necessary to intimate generally that in future, unless very special grounds are shown, they will not be prepared to sanction the appointment to any office, in respect of which their sanction may be requested, of any person who is or has been within twelve months a member of the council making the appointment."

FEES FOR POOR LAW MIDWIFERY.

J. J. H. says he attended a case of pauper midwifery which was difficult, necessitating his attention from 10 p.m. to 4.30 a.m., and subsequent attendance for twenty days, with occasionally two visits a day. For this he has claimed £2 as a special fee, which the guardians decline to pay, but offer 10s. 6d. Our correspondent asks whether he ought to accept the latter sum or refer the case to the Local Government Board.

*** Under Article 183 of the Consolidated Order of July, 1847, our correspondent has a strong claim for the special fee of £2, as the labour was really a difficult one, since it required six hours' close attention, and was, moreover, followed by three weeks' subsequent attendance, which could only have been rendered necessary by conditions other than those of natural labour.

ACTIONS AGAINST ISOLATION HOSPITAL AUTHORITIES.

IN reply to "J. H.," we may state as follows: (1) A discharging block is a separate building, usually containing a bathroom separating two dressing-rooms. The patient undresses in one dressing-room, leaves his infected clothing behind, and proceeds to the bathroom. After bathing he enters the second dressing-room and clothes in non-infected clothing. He straightway leaves the institution without again entering an infected portion of it. (2) In the Hereford case the patient had a final bath in the hospital proper, and passed from the bathroom out of the hospital through the matron's sitting-room. It was contended at the county court trial that re-infection took place during the patient's passage through that room. (3) Whether any case of scarlet fever should be discharged from hospital until all discharge from the nose, ear, etc., have ceased, is a question of opinion for each medical superintendent to decide.