help of a fellow-practitioner I performed version and delivered rapidly. The child was dead, and had a lower dorsal meningocele. This patient made a slow but uneventful recovery.

CASE III.

The third patient, also a primipara, aged 34, called me to see her at the eighth month for severe epigastric pain. I found a large quantity of albumen in the urine, although none had been present some weeks previously. Some opium quieted down the symptoms, and a fortnight's strict rest in bed, milk diet, careful purgation, and hot baths, considerably diminished the quantity of albumen; and the oedema which she had in her legs went down. In this case, especially as I suspected the pelvis of being of small size, I induced labour at the end of the fortnight by means of the insertion of a bougie; and when labour had progressed far enough for the os to be sufficiently dilated, gave chloroform, turned, and delivered a small living child. Both mother and child have done well, though the convalescence was rather slow.

Recent examinations of the urine from these three cases proved that the albumen has cleared up in all except the last.

I would especially draw attention to two interesting points in these cases: the variability of the presence of albumen previous to the symptoms, and the symptom of epigastric pain.

As a matter of routine I always examine the urine of women who engage me to attend them in confinement, but it would seem that this examination has to be made at fairly frequent intervals to avoid being taken unawares by the advent of albumen. With regard to the sudden onset of pain in the epigastrium, I was put on my guard by my father many years ago, and feel very grateful to him for the hint. It does not seem to be mentioned with much emphasis in books on midwifery or known very widely among practitioners.

Two other cases of albuminuria in pregnancy have come under my notice in recent years. The first was an elderly primipara who had convulsions and lost her first child, but recovered, herself; when, some years afterwards, she asked me to attend her, she went through her labour satisfactorily after being kept on a careful diet after the fourth month, with fairly frequent administration of aperients. The other was a lady whom I saw convalescing from severe eclampsia, and who still showed some partial aphasia, partial blindness in the left eye, and some anaesthesia of the hand. This patient suffers from chronic pyelitis.

Dr. Gowland of Faversham has published in the *St. Mary's Hospital Gazette*, November, 1911, two terrible cases of haemorrhage, and another case of albuminuria with a fatal ending, all three with albuminuria in pregnancy. I am thankful to say that I have never met haemorrhage complicating these cases, but some years ago I lost an elderly primipara from internal bleeding after confinement, due, I think, to an extensive tear of the os uteri into the peritoneal cavity. I can remember feeling wofully helpless in trying to restore this poor woman, and to check the bleeding.

Dr. Pinniger of this town very kindly gave me the advantage of his help and advice in two of my cases.

## CHICKEN-POX DURING THE PUERPERIUM.

BY

BERNARD MYERS, M.D.EDIN.,

HAMPSTEAD.

As the occurrence of chicken-pox during the puerperium is fortunately rare, I have been asked by an obstetrician to publish the following case:

A primipara, aged 30, had an uneventful parturition. The puerperium was normal also up to the tenth day. Then a vesicle, containing apparently clear fluid, appeared on the right buttock. In a few hours a second spot was seen upon the right breast immediately below the nipple. These spots were not itchy. The temperature was raised to 99° F.; the patient remained quite well in herself. As a married sister of hers was just convalescent from chicken-pox, I was on the look-out for any evidence of this complaint, more especially as my patient had kissed her sister three days before her confinement. I may mention that her sister was not aware at the time that she was suffering from chicken-pox, but her four children also subsequently developed the complaint, which they undoubtedly caught from their mother.

Twenty-four hours after the two initial spots manifested themselves the patient had a crop of spots on the chest and forehead which were typically chicken-pox. They were particularly itchy. The temperature rose to 101° F. The lochial discharges, which had practically stopped three days previously, now reappeared. In the course of two or three days from the appearance of the first spots the labia majora and breasts were literally covered with pocks. There were several on each nipple. A fair number were also seen on the face, body, legs, neck, ears, eyelids, and palate. Although there were not many pocks on the legs, a good crop was seen on the perineum and around the anus. She looked and felt distinctly ill on the fourth day of the rash; the temperature remained at 101° F.

Fearing that the first spot on the buttock might turn out to be chicken-pox I immediately stopped the child being fed by its mother; it was weaned and brought to another room.

Although much troubled by the intensity and irritation of the spots on the vulva the mother made an excellent recovery without any ill effects. Each spot was treated with 1 in 40 carbolic oil night and morning.

The baby developed a temperature of 100° F. for three days after leaving its mother and showed a tiny papular erythema upon its chest. It took its food well, had no vomiting or diarrhoea, and seemed to be quite undisturbed in any way by the rash, which vanished after four days. Was this an abortive attack of chicken-pox? The little papules came out in crops, and the condition was not like any of the ordinary skin rashes which babies are subject to.

The peculiarities of the case, as far as the mother was concerned, were the predilection of the pocks for the labia majora and breasts, parts which were, one may presume, receiving a more generous blood supply due to her recent pregnancy than would otherwise obtain. The appearance of the first spot on the buttock was unusual. This spot, although at first unlike chicken-pox, subsequently went through the usual changes in a typical manner.

# Memoranda:

## MEDICAL, SURGICAL, OBSTETRICAL.

### ABSCESS OF THE SPLEEN COMPLICATING MALARIA.

THE report by Lieutenant MacGregor, in the JOURNAL of February 3rd, recalls a case I met with many years ago in India. It was that of a British soldier who had served some years in India, and was much broken down by climate and service.

His final admission to hospital was for "ague," but after some weeks of irregular fever, it developed a remittent character, and was, in fact, of a more or less hectic type. This was long before the days of the microscope as an aid to diagnosis, and the true nature of the complaint was a matter of much speculation. He grew gradually weaker, and then complained of a pain in the left side. This was more or less referred to the base of the lung, but there were no signs or symptoms of pneumonia. Some friction sounds were heard, and it was thought he might have some dry pleurisy about the base of the lung. The spleen was not much enlarged (as made out by palpation), in fact, much less so than might have been expected considering the duration of the fever. He died somewhat suddenly one night, and at the *post-mortem* examination multiple abscesses of the spleen were discovered, which had never been suspected.

The case made a great impression upon me at the time, as I had never heard of a similar one, nor have I since, and, as noted by Lieutenant MacGregor, abscess of the spleen is not generally mentioned in textbooks. I could find no note at that time (it was in 1889 or 1890 at Lucknow). I write entirely from memory, which accounts for my somewhat "scrappy" notes. As a remarkable coincidence I may note that I quoted this very case when discussing rare and unusual cases with a medical friend this morning, only a few hours before reading Lieutenant MacGregor's case in the JOURNAL.

West Kensington, W. GEO. T. MOULD, Major I.M.S. (ret.).

### NERVOUS RETENTION OF URINE.

WITH regard to the treatment of nervous retention of urine by injection of glycerine into the rectum, I should like to state that this treatment entirely failed in a recent case. A fortnight ago a married lady who has had two children, and who was curetted seven months ago, and who has been quite well since, consulted me for retention. This was complete, and I had to use the catheter daily. On the fifth day she was examined under chloroform by a gynaecologist. The pelvic organs were found healthy.

There was a slight backward displacement of the uterus, obviously too slight to cause the retention. The displacement was rectified, and a pessary inserted. Three days later the patient was still suffering from complete retention. Having just read Dr. Edwards's note, I injected 2 drachms of glycerine into the rectum; the only effect was to cause thorough action of the bowels. Treatment by bromides and buchu was continued, the catheter being used at bedtime each night, the patient being allowed to live her ordinary life. Three days later the retention passed off. The patient never suffered from retention before, either in her confinements or after curettage or after operation for removal of the appendix. It was obviously a case of nervous retention.

Richmond, Yorks. HUGH M. EYRES, M.B.

## OXYURIS VERMICULARIS IN THE VERMIFORM APPENDIX.

A. B., a female, aged 34 years, was admitted to Scarborough Hospital on Sunday night, January 28th, suffering from acute abdominal disease. For eighteen months previously she had been treated at home for gastric ulcer, and under treatment appeared to improve considerably. Twelve months ago she attended the hospital as an outpatient, under the care of Dr. Salter, who advised removal of the appendix; but the patient refused treatment then. On January 28th, after mid-day dinner, she was taken with sudden pain in the abdomen, which she described as "doubling her up." She had no sickness. She called in her doctor, who advised immediate removal to hospital with a provisional diagnosis of perforated gastric ulcer. On admission her temperature was 99.4°, and pulse 100.

On examination she was extremely tender all over the abdomen, the abdominal muscles being rigid. There was slight distension over the lower part of the abdomen. There was no loss of liver dullness, and on being asked to put her finger on the point of greatest tenderness she placed it directly over McBurney's point. A diagnosis of acute appendicitis was made.

An incision was made over the right rectus muscle, the muscle pulled across to the left, and the peritoneal cavity opened into. The appendix was found to be enlarged and acutely inflamed at its tip, and was removed. No drainage was found to be necessary, and the abdominal wall was closed in layers. On slitting up the appendix after operation a most interesting condition was found. Two distinct collections of *Oxyuris vermicularis* were seen towards the base, whilst at the tip there was a small collection of pus under tension with a small concretion. The patient is doing well.

I am indebted to Dr. Salter, honorary surgeon to the hospital, for permission to publish notes of this case.

Scarborough. G. MACDONALD, M.B., Ch.B.Edin.

## ACUTE PAROTITIS FOLLOWING THE INDUCTION OF PREMATURE LABOUR.

THIS complication after the induction of premature labour has been previously observed,[1] but must be of sufficient rarity to deserve record.

The patient, who had previously had for some years a chronic oral sepsis—pyorrhoea alveolaris—was a primipara aged 32, who at the thirtieth week of gestation complained of shooting pains in the arms, neck, and throat, and some slight oedema of the legs was observed. Albumen in considerable quantity was found in the urine.

As the condition did not improve under medicinal treatment, steps were taken to induce labour on the morning of February 21st, 1911, under an anaesthetic, by the introduction of bougies into the uterus and packing the cervical canal with gauze.

The patient's temperature before the operation was 98°, and that evening rose to 99°. Labour occurred on the evening of February 24th, and was uneventful. The fetus was stillborn but not macerated.

About three hours after labour the patient became very collapsed, with a very rapid pulse. She was treated by hypodermic injections of pituitary extract, digitalin, and finally $\frac{1}{6}$ grain of morphine. Saline was also administered by the bowel, and she had rallied considerably by the next day.

On February 26th the temperature rose to 102°, and there was enlargement and tenderness of the right parotid gland. On March 1st the skin over the gland was distinctly red. On March 3rd an incision was made and a groove director passed up to the centre of the swelling, but no obvious pus escaped; a tube was inserted, and two days afterwards pus discharged freely from the wound and the temperature fell to 100°. The next day the temperature again rose to 102°; the vaginal discharge was offensive, and the patient complained of pain in the calf of each leg.

From this date the patient made a slow but complete recovery, retarded considerably by cystitis, probably due to catheter infection.

A culture taken from the parotid at the time of operation showed the infection to be from a staphylococcus.

A culture from the bladder showed a double infection, namely, *B. coli* and streptococcus.

It will be seen that this one patient presented nearly all the conditions and circumstances that have singly been credited by different theorists with the production of secondary parotitis, namely:

1. Some operative interference with the abdominal or generative organs.
2. A septic condition of the mouth.
3. The administration of an anaesthetic.
4. A dry condition of the mouth. (For nearly twenty-four hours the patient took very little fluid except by the bowel.)
5. A general septic condition, as shown by offensive lochia, the cystitis, and possibly a septic phlebitis of both legs.
6. The administration of opium, or some preparation of it.
7. The circulation of some toxin which might be excreted by the parotid (toxaemia of pregnancy).

The excessive salivation which marks some cases of toxic pregnancy should be noted here.

Norwich. ARTHUR CROOK, M.R.C.S., L.R.C.P.

[1] *Lancet*, April 17th, 1886, S. Paget, quoting J. M. Duncan (one case).

## THE VALUE OF ANCHORED DRESSINGS IN SURGERY.

I NOTED the article by Mr. Lynn Thomas on the use of anchored dressings in surgery (BRITISH MEDICAL JOURNAL, February 3rd, 1912), and felt a little interest in the matter, since for the past fifteen and a half years I have used this method in nearly all abdominal cases, and am therefore satisfied as to its utility. But it occurred to me to ask Professor William Thorburn, from whom I gained this hint in 1896, if he could tell me the origin of the idea. He has sent me a communication from which it would be worth while to quote.

It is very interesting to see so old an idea brought into prominence suddenly. The history of things is much as follows: In 1883 when I was Mr. Hardie's house-surgeon, he used to employ very freely the old-fashioned button sutures, obtaining thereby an evenly distributed tension. About this time and before, my late father, who did a good many abdominal sections, especially ovariotomies, used for these, as well as for his perineal operations, perforated bone rods through which the sutures were tied, and which produced the same result of diffused tension. A few years later, when we began to get better operation results, and when it ceased to be necessary to do constant dressings, I began employing, especially over the abdomen, and particularly in such conditions as radical cure of umbilical herniae, gauze pads placed under the sutures such as those described by Mr. Lynn Thomas. I cannot fix any date, but I clearly recollect that when J. W. Smith became Resident Surgical Officer at the Manchester Royal Infirmary (1891) he remarked on the usefulness of the method, and I have certainly practised it for over twenty years. It never occurred to me that everybody else would not do so in similar cases, and I have certainly been in the habit for very many years of teaching it to students as the best method for many dressings. I have certainly not made it so universal as Mr. Lynn Thomas is now doing, and there is this difference, that I have always regarded the sutures over a gauze pad as essentially a means of providing close apposition and diffused tension, and I have been in the habit of putting an over-riding dressing on top of the sutures with a view to covering the points at which they came through the skin. This under modern conditions is probably unnecessary.

In the BRITISH MEDICAL JOURNAL of February 10th there is a further note on the use of this form of dressing by Mr. Jocelyn Swan which will well repay perusal by those interested in the method. I may add that in the radical cure of inguinal hernia in the adult patient I have for the past few years used the anchored gauze pad without the over-riding dressing, and the patients have

found this more comfortable than the usual dressings with spica bandage. In children for the past seven years I have dispensed with any form of dressing after the operation for inguinal hernia.

Manchester. J. Howson Ray, Ch.M., F.R.C.S.

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

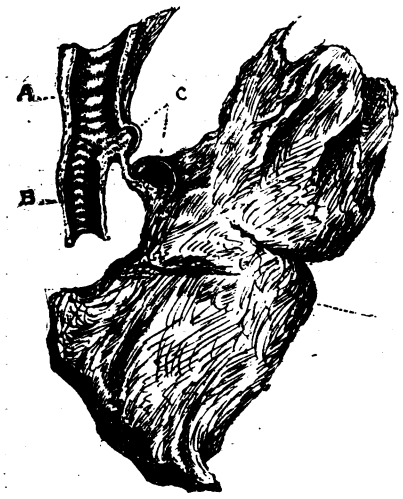
### ROYAL UNITED HOSPITAL, BATH.

TRAUMATIC RUPTURE OF THE RIGHT BRONCHUS FROM INTRATHORACIC PRESSURE.

(Under the care of W. G. Mumford, M.B.Lond., F.R.C.S.Eng.)

[Reported by A. J. Bruce Leckie, M.B., Ch.B.Edin., late House-Surgeon and House-Physician.]

J. M., aged 9, was admitted in June, 1910, on account of injuries received by being knocked down by a motor, one of the wheels going over him. When first seen he presented a marked bloated appearance. The whole face was enormously swollen, so much so that the eyes were obscured completely by swelling of the eyelids. The puffy swelling of the face was rendered more ghastly by a slight cyanotic tinge. He was continually pleading to have his eyes opened, and was perfectly conscious in every way. No injuries could be found except a few scratches. No fractured ribs could be detected. There was marked swelling of the tissues of the thorax and abdomen. The swelling was found to give the characteristic crackling of surgical emphysema. The air gradually spread over the whole body, with the exception of the upper parts of the scalp. The crackling could be easily detected in the fingers and toes. Thus the patient presented a remarkable inflated appearance. He only complained of pain in the back. As the condition got worse, considerable dyspnœa made itself evident, the respirations being 38 to 48. The temperature was 97° and the pulse 144 to 148.




Sketch of specimen of right lung, trachea and bronchi from behind. A, Trachea opened from behind: B, left bronchus; C, torn surfaces of right bronchus; D, right lung shrunken with formalin.

As it was obvious that there was severe injury to some portion of the respiratory tract, it was decided that very little could be done. The patient was eased as much as possible by the administration of oxygen and by punctures in the skin to allow the escape of air, which occurred with a loud hissing noise. The patient died the following morning, having lived about eight hours.

At the *post-mortem* examination it was found that air was present not only in the superficial tissues, but in the peritoneal and right pleural cavities. The right bronchus was found completely torn across at its junction with the trachea and attached to it by some connective tissues. No fractures of any bones had occurred.

The condition is a rare one, and could only be expected to occur in children, where the elasticity of the thoracic wall allows of considerable compression. The sketch shows the injury, and was drawn from the specimen. I am indebted to Mr. Mumford, assistant surgeon to the hospital, for kindly allowing me to publish this case.

# British Medical Association.

## CLINICAL AND SCIENTIFIC PROCEEDINGS.

### NORTH OF ENGLAND BRANCH: NEWCASTLE-ON-TYNE DIVISION.

The fourth winter scientific meeting of the Division was held on Friday, February 16th, at the Royal Victoria Infirmary, Newcastle-on-Tyne, when sixty medical men were present.

*Salvarsan in Syphilis.*

Dr. R. A. Bolam dealt with the present position of salvarsan as a proven remedy in syphilis. After recalling the claims advanced in the introduction of the remedy and pointing out the difficulty of achieving sterilization by single massive doses, the present attitude of Ehrlich was discussed. The notable pronouncement that syphilis in man belonged to those diseases which it was not very easy to influence by salvarsan was commended to the notice of the too enthusiastic supporters of the remedy. Numerous accidents after the use of the drug, even in cases where after careful investigation a patient was determined to be a fit subject for its administration, must compel one to consider every case most carefully before advising a patient to submit himself. The risks were considerable; the advantages, except in cases resistant to other medications, for the most part those of rapidity only. Sensory nerve complications undoubtedly occurred, and it was suggested that this feature was becoming apparent by reason of the increased use of the intravenous method. In no instance should the use of mercury be dispensed with, although the period of its exhibition might be somewhat curtailed. No warrant would be found for the routine use of salvarsan. It should be reserved for special circumstances.

*Ruptured Cartilage of the Knee-joint.*

Mr. Collingwood Stewart gave a demonstration on ruptured cartilage of the knee-joint. He first dealt with the anatomy of the joint and demonstrated the difference between the internal and external semilunar cartilages. The external was more free, being attached to the capsule in its anterior and posterior portions, while the middle was free, the cartilage being separated from the external lateral ligament by the tendon of the popliteus muscle, which grooved the cartilage. The internal cartilage had a strong attachment to the broader internal lateral ligament. The external cartilage and the space it contained was almost circular, while the internal semilunar and its space was elliptical, indicating that there was antero-posterior movement upon the internal, and rotation only upon the external semilunar. Dealing with the mechanism of the joint, it was shown that when rotation took place the external condyle was held firm on the tibia, and the internal condyle rotated backwards—the external condyle being the pivot. When the joint was flexed the internal condyle was placed upon the posterior part of the semilunar. More movement was permitted between the tibia and internal condyle than between the tibia and external condyle. On examining the position of the limb when these ruptures occurred it was found that in the great majority of cases it was the same. The joint was flexed and then bent suddenly inwards so that all the strain was thrown upon the internal lateral ligament and would tend to separate the inner bony surface of the joint—between these the cartilage would be caught and fractured. The rupture was practically always posterior, travelling forwards so that the anterior end was intact. An analysis of 350 consecutive cases showed that miners and footballers comprised 88 per cent. and the miners alone 65 per cent. External cartilages were seldom ruptured, 3½ per cent. only, and then only by very severe direct injuries. Discussing the diagnosis, the following point swere stated as being nearly always present:

1. History of the injury occurring with the joint in the position above mentioned. This history was said to be of the greatest importance.
2. Locking of the joint. When this was present with the typical history it was absolutely confirmatory evidence.
3. Synovitis following in a few hours.

Ramsay fulfilled for many years. He settled in Carlisle soon after his marriage in 1893, and his life there was from the beginning successful. A certain degree of bluntness of speech and brusqueness of manner which distinguished him by no means stood in his way; indeed, they even served to inspire confidence so soon as it was realized that behind them lay thorough kindness of heart coupled with dislike of anything in the nature of cant, and real knowledge of his work, manual dexterity, and coolness in emergency. In 1903 he was appointed to fill a vacancy on the surgical side of the staff of the Cumberland Infirmary, and a year later, on the occurrence of a further vacancy became full surgeon. From that time forward his repute among the public and his professional colleagues had been constantly growing. His qualities as an individual and as a surgeon are, however, best described in a letter from his fellow surgeon, Dr. LEDIARD, who writes as follows:

His forte was surgery, and it was surgery that drew him into the appointments he held after graduation. As surgeon to the Cumberland Infirmary, Dr. Ramsay built up a reputation of no mean order, and his death comes as a disaster to that institution, for he justified at every point the confidence his patients and his colleagues placed in him. A splendid nervous system controlled and an unalterable coolness pervaded his operative skill, which was attended with brilliant success. Cautious rather than daring, discriminative rather than hasty, it is small wonder that he had reached a high level of surgical confidence in the hospital no less than in the city of Carlisle and in the border land adjoining. A man of few words but eloquent in deeds, he was as sure and gentle in handling tissues as a connoisseur would be with a delicate museum treasure. Such a surgeon would have added strength to any hospital in the world, and withal Dr. Ramsay possessed a modesty and an unselfishness rarely encountered in these pushing advertising days, and he was the first to recognize excellence in others and the last to throw a stone. There is an old Cumberland term, "janick," which embraces a lot, and Dr. Ramsay was "janick" to the core, for no mean nor contemptible action ever soiled his escutcheon, and, as a colleague in the Cumberland Infirmary, he was ever courteous, generous, and fair-minded. Justice was nailed to the mast of the ship in which he sailed, and his tranquillity was superb. It is to be hoped that an effort will be made to place some permanent record of Dr. Ramsay's work in the hospital in some suitable manner.

In his student days Ogilvy-Ramsay attained considerable distinction on the running path and as a football player, and was an active member of the University Artillery Volunteers. In later life he proved a keen golfer, and took such a zest in the game as to be an especially pleasant companion on days off. Of late years, however, increasing occupation made golfing a matter of difficulty, and he had taken up croquet as a fine art. Dr. Ogilvy-Ramsay, whose marriage in 1893 has already been mentioned, is survived by his wife and by a son and a daughter.

The interment took place at Closeburn in Dumfriesshire, on February 17th.

### HENRY FITZGIBBON, M.D., T.C.D., F.R.C.S.I.,

CONSULTING SURGEON TO THE ROYAL CITY OF DUBLIN HOSPITAL.

DR. HENRY FITZGIBBON died at his residence, Fitzwilliam Square, Dublin, on February 23rd.

Henry Fitzgibbon, who was in his 71st year, was the son of the late Mr. Gerald Fitzgibbon, Q.C., Master in Chancery, and a brother of the late Lord Justice Fitzgibbon. He received his medical education at Trinity College, Dublin, taking the degree of M.B. in 1866, and the M.Ch. in the following year. He became a Fellow of the Royal College of Surgeons in Ireland in 1881, and was elected President in 1888–9. He was appointed Visiting Surgeon of the Royal City of Dublin Hospital in 1874, and after twenty years resigned in 1895. He was appointed Consulting Surgeon to the same hospital in 1903, a post he held at the time of his death. He was Surgeon also to the Lock Hospital. For many years he was Principal Medical Officer to the General Post Office. Dr. Fitzgibbon was a member of the Board of Superintendence of the Dublin Hospitals, and a Visitor in Lunacy under the Court of Chancery. His life was one of great activity, for in addition to a large private practice he was Medical Referee to numerous life assurance societies, and a member of several medical boards. He was an ex-President of the British Postal Medical Officers' Association. Until recent years, when his health began to fail, he was a well known figure in Dublin, as he used to drive an exceptionally high tax-cart. He contributed to the medical journals various papers on surgical subjects, especially on the treatment of tetanus and fractures.

At a specially-convened meeting of the Resident Executive of the Association of Irish Post Office Clerks, held on February 23rd, the following resolution was adopted:

That we, the Resident Executive of the Association of Irish Post Office Clerks, have learnt with the greatest regret of the death of Dr. Henry Fitzgibbon, so long and so honourably associated with the Dublin Post Office, and on behalf of the members of the Association respectfully offer to Mrs. Fitzgibbon and family the deepest sympathy of the Association in their great sorrow.

# Universities and Colleges.

## UNIVERSITY OF CAMBRIDGE.

*Appointment.*

DR. GRAHAM SMITH has been appointed Lecturer in Hygiene.

*Degrees.*

The following degrees have been conferred:

M.D.—R. F. V. Hodge.
M.B., B.C.—H. K. Griffith.

## UNIVERSITY OF BRISTOL.

THE following candidates have been approved at the examinations indicated:

FINAL M.B., CH.B. (*Part I*).—G. F. Fawn, W. P. Taylor.
FINAL M.B., CH.B.—E. V. Foss, J. R. Kay-Mouat, P. Moxey.
D.P.H.—T. J. Williams.

# The Services.

## THE R.A.M.C. IN RELATION TO OTHER ARMS.

LIEUTENANT-COLONEL F. WYVILLE THOMSON, commanding the 2nd Scottish General Hospital, R.A.M.C. Territorial Force, delivered a lecture to the East of Scotland Tactical Society on the relation of the R.A.M.C. to the other arms of the service. The chair was occupied by Lieutenant-Colonel Sir Joseph Fayrer, Bart., Superintendent of Edinburgh Royal Infirmary, who said that the relations of the R.A.M.C. to other branches were most important, and it was the duty of every officer to recognize and understand them.

The lecturer, in the course of his remarks, said that a most essential factor for success was that the commanders of bodies of troops must work in close conjunction with the medical officers of their commands. In all strategical and tactical movements the medical requirements should receive consideration, so that suitable ground for camps, proper water supply, and sanitary arrangements might been chosen. When an engagement was imminent the administrative medical officer should know the disposition of the troops and the objective, so that the medical units might be properly allotted to given areas. Bad medical tactics could be as great a source of loss and danger as defective fighting tactics. Another important point was intercommunication in the field, particularly with the medical units. To ensure proper knowledge of such details strictly medical manœuvres should form part of the training of every field unit, so that brigades might practise with their field ambulance, or each battalion with a section. In such field exercises co-operation of combatant and medical officers should be practised. Another most important point was with regard to sanitation. In the event of mobilization of the Territorial Force a quarter of a million of men would pass in a few hours from a state of sanitary civilization into that practically of savages. Sanitation as understood in peace time would vanish and the soldier became responsible for the makeshifts, the disposal of insanitary refuse, and the protection of the water supply from contamination. This ought to be taught the soldier thoroughly in peace time, to numbers not larger than companies, so that every man would be aware of the dangers of sanitary transgression.

# Public Health AND POOR LAW MEDICAL SERVICES.

## VACCINATION IN THE ISLE OF MAN.

ON February 20th Mr. Ambrose Qualtrough moved in the Manx House of Keys the second reading of a bill to amend the law as to compulsory vaccination by allowing conscientious objectors to vaccination to escape the operation of the law. Dr. Marshall, member for North Douglas, strongly opposed the bill, which, he urged, would be a retrograde step. After a debate, the second reading was rejected by 15 votes to 6.

# Medical News.

THE next dinner of the Irish Medical Schools' and Graduates' Association will be held at the Hotel Cecil on Saturday, March 16th, at 7.30 p.m.

DR. W. SIMPSON, of Buckie, Banffshire. was recently presented with a pony and trap, "in recognition of forty years of professional and public services."

H.R.H. PRINCE ARTHUR OF CONNAUGHT, K.G., has consented to become patron of the twenty-seventh Congress of the Royal Sanitary Institute, to be held at York in July next.

SIR RICHARD DOUGLAS POWELL is giving two lectures on the medical aspects of life insurance at the Middlesex Hospital Medical School. The first lecture is announced for this day (March 1st), at 3 p.m., and the second for March 8th, at the same hour.

THE National Organization Committee for the Berlin Congress of Obstetrics and Gynaecology, which is to take place next September, has elected as delegates for the United Kingdom Sir Alexander Russell Simpson, Dr. Herbert Spencer, and Dr. Macnaughton Jones. The latter has also been appointed reporter on the subject of the surgery of the peritoneum.

MR. THOMAS HAYES, clerk to the governors, writes to inform us that the statement which appeared in some newspapers, on February 22nd, implying that St. Bartholomew's Hospital is offering treatment for a weekly payment of £2 is entirely without foundation. No such offer has been made, nor has there at any time been a suggestion of making an offer of the kind.

THE members of the Balneological and Climatological Section of the Royal Society of Medicine will dine together at Pagani's Restaurant on the conclusion of their meeting on March 6th. In order that proper arrangements may be made, those who propose to be present at the dinner are requested to communicate early with the Honorary Secretaries of the Section at 15, Cavendish Square.

THE report submitted at the annual meeting of the West End Hospital for Diseases of the Nervous System on February 23rd stated that the out-patients' attendance had increased during the year by over 18 per cent. (from 25,618 to 30,426), and that the level of the annual income from subscriptions and donations had been well maintained. A small chapel is in course of construction.

The issue of the *Friend of China*, the organ of the Society for the Suppression of the Opium Trade, for February contains a summary report of the Hague Opium Conference, and in a supplement is printed a translation of the internation convention settled at the conference. The scope of the convention was indicated in the article published in the BRITISH MEDICAL JOURNAL of February 3rd, 1912, p. 261.

THE report submitted at the annual meeting of the Governors of Queen Charlotte's Hospital on February 26th showed a debit balance on the year of £1,970, which was ascribed to a falling off both in donations and legacies. With regard to the future, it was estimated that the National Insurance Act would entail direct fresh expenditure of £130 per annum, against which there would be no offset, since the majority of the patients treated were not persons who would be entitled to receive maternity benefit.

THE discussion on partial thyroidectomy under local anaesthesia, with special reference to exophthalmic goître, opened at the joint meeting of the Surgical, Medical, and Anaesthetic Sections of the Royal Society of Medicine on February 27th, was adjourned to a special meeting to be held on March 5th at 5.30 p.m. Among those who will take part in the debate on this occasion will be Mr. Charters Symonds, Mr. A. E. Barker, Mr. Donald Armour, Mr. Walter Edmunds, Dr. J. Blumfeld, Mr. C. H. Fagge, Dr. H. J. Scharlieb, C.M.G.; Dr. G. A. H. Barton, Mr. Rupert Farrant, and Mr. James Berry. Dr. McCardie, President of the Anaesthetic Section, will preside.

THE fifty-sixth annual report of the Royal National Sanatorium, Bournemouth, for the year ending December, 1910, deals chiefly with the income and cost of maintaining the sanatorium, which holds 85 beds fully occupied throughout the year. The rules for consumptives and the hours for meals are also included, and both alike are excellent. There is little to criticize in the medical results of the sanatorium, as no statistics are given of the benefit received, neither is there any mention of tuberculin treatment, both of which might receive attention in next year's report.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society was held at 429, Strand, London, W.C., on February 16th, Dr. de Havilland-Hall in the chair. Winter weather always increases the claim list of the society, and, as usual, the sickness claims received in the early part of the year have been very numerous. On the other hand, they have been for the most part of a light nature and of short duration. Since the business commenced in 1884 every year has shown an increase in the reserves, which now amount to over a quarter of a million sterling. From the first it was noted that, although the total sickness experience of the society did not exceed the amount expected and provided for in the tables of contribution, yet the number of members who remained on the funds until they were entitled to only half pay was much in excess of the expectation. It is evident that medical men are less likely to claim sick benefit than those in other occupations, but that a somewhat large percentage of them are liable to very long, and in too many cases permanent illness. For the payment of these permanent cases a big reserve is of course required, and, as the committee has always considered that this is a most important branch of the operations of the society, a large amount of money is at each valuation of the business set aside to make this quite secure. Prospectuses and all further information on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

THE fourth annual report of the King Edward VII Sanatorium, Midhurst (July, 1909, to July, 1910; 1s.) is a very extensive and excellent report of the work done in this sanatorium for twelve months. It is drawn up by the medical superintendent, Dr. Bardswell, assisted by the senior assistant medical officer, Dr. Burra; the pathological report is from the pen of the pathologist, Dr. Radcliffe, and Dr. Bulloch has assisted in the pathological work by experiments in his own laboratory on the various cultures. A few figures regarding the cases admitted and discharged are of interest: 271 patients were discharged during the year—174 males and 97 females. The cases are classified into the three stages of Turban-Gerhardt. In the first stage 91 cases: disease arrested in 56.1 per cent., much improved 31.8 per cent., improved 5.5 per cent., stationary 5.5 per cent., worse 1.1 per cent. In the second stage, 116: 12.9 per cent. arrested, 45.7 per cent. much improved, 20.8 per cent. improved, 6.9 per cent. worse, 9.5 per cent. stationary, 4.3 per cent. died. Stage three, 53 cases: 1.9 per cent. arrested, 20.7 per cent. much improved, 35.9 per cent. much improved, 17.0 per cent. stationary, 20.7 per cent. worse, 3.7 per cent. died. The remaining 11 cases were placed in a fourth group, and in these no tubercle bacilli were found in the sputum at any time. Of 683 patients discharged between 1906 and 1909, 197 were in the first stage, and 88.3 per cent. were well in 1911 and 7 per cent. dead. Of those in the second stage 73 per cent. were well in 1911 and 20.8 per cent. dead; and of those in the third stage 41.7 per cent. were well in 1911 and 53.6 per cent. dead, figures which show that the mortality of advanced cases is high notwithstanding sanatorium treatment. The laboratory report consists of an examination of a few cases of secondary infections treated by vaccines, the results of which are disappointing, as they produced no beneficial effect. There is also a careful examination of von Pirquet's reaction, but the only conclusion that Dr. Radcliffe is able to draw from them is that in a doubtful case a negative result probably means absence of tuberculosis. Malinejac in 1909 stated that it is possible to make a diagnosis of pulmonary tuberculosis in its earliest stages by estimating the total density of the urine and the number of days which this acidity lasts. According to him the activity is much higher in cases of tuberculosis than the normal, and lasts longer. Dr. Radcliffe was unable to corroborate this in the few cases he examined. The report closes with Dr. Bulloch's investigations of cultures from the various strains. A youngish rabbit was inoculated in each case with 0.01 mg. of the culture, and in every case the rabbits increased in weight and remained healthy. An abscess formed at the seat of inoculation in each case. The investigation is completed in fourteen of the strains, and in each case the virulence for rabbits was nil, so that the strains may be put down as human in type. The whole report is well worthy of study. There is a mistake on page 3 of the preface, repeated on page 44, where the figures 14 should read 9.