baby was born in the chamber vessel. The placenta was expressed with some difficulty fifteen minutes afterwards, but came away quite intact. I had a good deal of trouble in stopping the haemorrhage after the placenta came away, for I could easily get hold of the uterus and make it contract, but it seemed to have very little retracting power, and filled with blood as soon as it was left. A hot continuous intrauterine douche was administered, ergot and strychnine given hypodermically, and the uterus held firmly for nearly one and a half hours before it was safe to leave it. From then onwards, however, there was no further haemorrhage of any note. Two pints of saline solution were given intravenously and pills of ergotin, quinine, and strychnine prescribed. The case ran a nearly normal course except for a slight rise of temperature to 100° during the first two days, probably reactionary and due to the extremely anaemic condition of the patient. The pulse, which immediately after the confinement was hardly perceptible at the wrist, was at 10 o'clock that night 110 and fairly full and strong.

The stillborn fetus, a female of the eighth month in development, weighed 5¾ lb., and appeared quite normal and healthy. It had probably died the day before delivery, after the convulsive movements the mother had mentioned. The placenta was quite normal in every respect, but from the dark blood clots still adherent to it it appeared to have been separated from its uterine attachment over half of its surface; otherwise it presented no unusual features.

The points of interest in this case appear to me to be: First, the spontaneous emptying of the uterus without any previous signs of labour—an event which probably saved the patient's life. The loss of blood had in all likelihood so far reduced the general blood pressure, that what was left of the contracting power of the uterus was able to prevent further dilatation and to stop the haemorrhage, which had probably become feeble *in utero*, this action no doubt being stimulated by the pituitary extract. Why the labour should end so precipitately I can offer no opinion, unless it was again due to the action of the pituitary extract. The second feature of interest was the fact that I was able to get the uterus to contract and finally to retract so as to stop the haemorrhage. It is usually considered that in cases of concealed accidental haemorrhage the uterine muscle is so diseased as to have lost the power of contracting and retracting. The practically uninterrupted recovery of a patient who was so near to death must be rare. As to the predisposing cause of the haemorrhage, was the uterine muscle attenuated as a result of the attack of diphtheria, or was the nervous mechanism poisoned and stimulus interrupted by that malady? And, if so, why was the uterus able to contract sufficiently to expel the fetus and to remain contracted later? I may add that the urine was quite normal in quantity, acid reaction, specific gravity 1020, and at no time contained any abnormal constituents.

TECHNIQUE OF ANALGESIA IN INTRANASAL SURGERY.

By WILLIAM WILSON, M.D., B.Sc.,
HONORARY ASSISTANT SURGEON, ST. JOHN'S HOSPITAL FOR THE EAR, MANCHESTER.

RECENT discoveries have so modified the indications for general anaesthesia in intranasal surgery that, granted ordinary self-control by the patient and delicate handling by the surgeon, the discomforts and dangers of efficient analgesia are considered less than those of general anaesthesia. The only intranasal operation really unsuitable for local analgesia is the frontal sinus obliteration.

I have found the technique about to be described highly satisfactory in operations upon the turbinal bones and nasal septum; indeed, a patient who has slept through the greater part of the operation may be able, with a little assistance, to walk back to bed. The employment of chloroform (without admixture with ether), injections of cocaine and adrenalin, alone or in combination, and post-operative packing with adrenalin are absolutely unjustifiable in operations on the nose, and will sooner or later lead to catastrophe. Moreover, with or without the use of a general anaesthetic, the injections of cocaine and adrenalin lead to marked excitability, difficulty of breathing in the recumbent posture, and excruciating headache (through adrenalin vasomotor stimulation), with the need of constant administration of hot coffee and aromatic spirits of ammonia. The confidence of the patient is lost and the operation is rendered more difficult.

One hour before the commencement of the operation a hypodermic injection of ¼ grain of morphine with $\frac{1}{100}$ grain of atropine sulphate should be given and the nasal passages packed with gauze soaked in equal parts of 10 per cent. cocaine and adrenalin. This should be done with reflected light, so that narrow strips can in most cases be passed behind a marked deviation. The patient should be allowed to remain as quiet as possible for thirty minutes, when he is transferred to the operating table and the gauze strips are removed, a small portion of cotton-wool being inserted far back in each nostril to soak up any overflow from the following infiltration of urea-hydrochloride-quinine solution. In the case of an operation upon the nasal septum three points for injection will suffice on each side; these points are at the angles of a triangle with the base corresponding to the junction of mucosa and skin just behind the anterior nares and the apex over the vomer, its exact position being dependent upon the area infiltrated by the two injections in front. If the inferior turbinals are to be removed two injections will suffice on each side, one just behind the anterior extremity and the other at the junction of the middle and posterior thirds. The syringe employed should be all metal and the needle of the finest aperture procurable with bevelled tip without point. Dental needles are most convenient. The solution employed should be 1 per cent. quinine-urea-hydrochloride, and the amount injected should not be stinted. The nose is again packed with gauze wrung out of the cocaine-adrenalin solution, and in about twenty-five minutes the operation is commenced.

The haemostasis is perfect, and the analgesia is so thorough as to be truly anaesthesia, even the tactile sensibility being in most cases destroyed. There is but little emotional distress, and I have known patients, on being told to close the eyes and sleep, who have done so, and snored away during the entire operation, the only disability being that the head has had to be steadied by an assistant. The analgesia persists as a rule for about eight to twelve hours. I have not met any instance in which it has lasted several days, as claimed by other observers. There is no after-sickness, and the patient is free to go about his business in about twenty-four hours. In consequence of the exudation caused by the quinine-urea solution, there is some after-swelling, but this seems to minimize the possibilities of post-operative oozing.

It is quite possible to drain and explore the antrum of Highmore by this method, as is the routine practice of many American surgeons, but time is required before the advantages of efficient analgesia are fully appreciated in this country. It is safe to predict that the future will see further rapid progress as new chemical discoveries of non-toxic anaesthetics are announced.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

A CASE OF CEREBRO-SPINAL MENINGITIS.

C. W., aged 23, a driver A.S.C., was removed on April 9th to the Red Cross Hospital, Trent Vale, and from there, on April 10th, to the Bucknall Isolation Hospital. At the onset there was nausea, with violent headache and retraction of the head, and the temperature rose to 103° F. When admitted into the isolation hospital he was quite unconscious, with the head greatly retracted and the back curved; there was slight squint, increased reflexes, Kernig's sign, on the left buttock a patch of spots, and on the lips a well-marked patch of herpes. The pupils were inactive and contracted, *tache cérébrale* very marked; the urine was passed freely, and contained no albumin. During the second day incontinence of urine and faeces set in, and continued during the illness. Lumbar puncture was performed on April 10th with Barker's needle. Lumbar fluid was sent to the Health Laboratory, Manchester, for examination, and was said to contain *Meningococcus intracellularis*. The jaws were so clenched that it was impossible to obtain a swab from the throat. Soamin was given intramuscularly in 6-gram doses daily, until 100 grams had been given. Lumbar puncture was made every four days (six times altogether); 30 to 60 c.cm. of fluid was removed each time, and 15 c.cm. of antimeningococcus given after the withdrawal of fluid on each occasion until 75 c.cm. had been given. The puncture was made each time that

there was a rise of temperature. On April 30th the temperature fell to normal, pulse 112, respiration 28, and the patient became more conscious, and took food well. On May 4th he was able to move his head about freely, and to raise himself from the pillow and to answer questions well; he gave a history of himself and his family; he began to take solid food on May 8th. The improvement was maintained also on May 9th and 10th, and he appeared to be going on fairly well.

On May 11th temperature fell to 96.8° F.; the pulse was 116 and very feeble. Violent sickness set in at 11.55 a.m.; he could not take any liquid food, and became restless and quite unconscious. There had been no action of the bowels for twenty-four hours, and the urine was scanty.

On May 12th the pupils were contracted, the head retracted, and he was breathing heavily; the pulse was 60 and feeble. Lumbar puncture was made, but without relief. Ether and digitalis were given hypodermically; the patient sank and died at 11 p.m. No *post-mortem* examination was allowed.

Stoke-on-Trent. C. H. PHILLIPS, M.D.

TREATMENT OF WOUNDS.

I PUBLISH this note in order to give the medical profession at home and abroad an opportunity of employing the following treatment for septic wounds:

Mix equal quantities of pure ichthyol and glycerine, spread it on boric lint by means of a camel-hair brush, and apply it to the wound. The wound should be dressed daily. If there is also suppuration from a sinus, as in the case of a bullet wound, it should be syringed out with pure spiritus vini rectificatus; in this case dressing with gauze is preferable to boric lint.

This treatment produces a healthy granulating surface in a few days, and does not cause any irritation of the wound. The daily dressing has a great advantage over fomentations, which necessitate frequent changing and disturb the patient, besides prolonging suppuration. The less moisture about a wound the better. I have almost discarded that barbarity—the drainage tube. The results obtained by this treatment are most brilliant.

C. W. DUGGAN, Major R.A.M.C.

Military Hospital, The Barracks, Lincoln.

COMPLETE INVERSION OF THE UTERUS WITH PROLAPSE: RECOVERY.

THE following case is similar in many respects to that recorded by Dr. Oag:

On the morning of August 22nd, 1914, I was called to see Mrs. W., aged 23, primipara. During the previous night she had felt some slight colicky pains, and in the morning thought she was only commencing labour; but when I examined her the head was on the perineum. As the pains were deficient I applied forceps, and the child was born easily at 11.30 a.m. The uterus contracted well, and about ten minutes after the birth of the child (a healthy female) the placenta was coming out of the vagina; in removing it with the usual care, I found it bringing along with it, right outside the vulva, the completely inverted uterus. There was practically no haemorrhage; as the placenta was not markedly adherent, I detached it, and tried to reduce the inversion under chloroform, but after about twenty minutes' manipulation the patient became pulseless and so profoundly collapsed that I deemed it advisable to desist. The cord was of the usual length, and in every way normal. My efforts—and those of the district nurse, who was also in attendance, and whose help and inestimable services cannot be overestimated—were afterwards directed to combating shock, which was extreme, by means of pituitary extract, hypodermics of strychnine and digitalis, saline under the breasts, and other usual means. In the afternoon the patient rallied, and she was removed to the Maternity Hospital, Edinburgh; but owing to difficulty of securing suitable transport, it was nearing 7 p.m. when she reached the institution in a motor ambulance. Her condition remaining satisfactory, she was given an anaesthetic on admission, and the inversion carefully reduced by Dr. Eddington, not, however, without much difficulty; shock was extreme. After a tedious and perilous convalescence the patient recovered, and is now in perfect health.

The case, like that of Dr. Oag's, is of great interest owing to the following facts:

1. The extreme rarity of complete inversion—1 in 200,000 confinements.

2. The mortality, said to be as high as 66 per cent. This mortality, high though it be, is probably an underestimate.

3. The absence of any apparent cause. Cord usual length; no abnormality; no torsion made on cord. Placenta not adherent.

Since writing these few notes I have read Dr. Carruthers's illuminating remarks on the same subject with very great interest and pleasure.

Kirkliston. PETER STEWART, M.D.

CARCINOMA OF CERVIX: TWIN DELIVERY WITHOUT LACERATION.

MADAME T., aged 37, a multipara with three children, the youngest aged 7, was admitted into a temporary hospital for women at Châlons-sur-Marne on December 24th, 1914. A French army doctor had seen the case, and as the pains were very distressing he had given morphine hypodermically before sending the case into hospital. There was a history of loss of matter and discharge, often blood-stained, for at least four months. The patient was very sallow, and said she had not been at all well during pregnancy. The uterus corresponded in size to that of full-term pregnancy; there were intermittent contractions, and there was so much tenderness that the fetal parts were difficult to locate. There was a considerable quantity of very foul blood-stained discharge coming away from the vagina.

The os was about the size of a five-shilling piece, but the edges were very hard and irregular and bled easily, and examination with a speculum showed all the naked-eye appearances of an early carcinoma of the cervix. Next day, as very little progress was being made, Dr. Evrain kindly saw the case with me in consultation. He also had no doubt about the diagnosis, but thought that spontaneous delivery was possible, and that a Champetier de Ribes's bag might help, as the membranes had ruptured before the patient came into the hospital. The bag, unfortunately, soon began to leak, so was of little service. Labour was very tedious, and the patient was so exhausted that when the os was three-quarters dilated I decided to perforate the fetal head, as no one had been able to hear the fetal heart.

Delivery was effected slowly with ordinary long curved forceps and a female baby of rather small size was delivered, but it then became quite evident that it was really a case of twins; as the second child was presenting by the vertex delivery was effected with forceps of a very puny living female child weighing 5½ lb. The placenta with two cords attached came away without any trouble, and pituitary extract was given hypodermically. No lacerations could be felt in the cervix, the os contracting down well.

The puerperium was normal apart from the discharge caused by the growth and the uterus involuted well. The baby never cried strongly and died within three days.

On January 9th examination of the cervix showed that there was slight extension on to the posterior vaginal wall but no severe lacerations. The patient was seen at her home towards the end of January and also about the end of February; the growth was extending rapidly posteriorly, and there was so much pain that narcotics had to be given frequently.

The case is, I think, interesting from two points of view: First, the comparative rarity of carcinoma of the cervix complicating pregnancy, and, secondly, the fortunate fact of there being twin pregnancy, the heads being comparatively small made delivery without any laceration possible.

C. DYSON HOLDSWORTH, M.D., B.S.Lond.,
M.R.C.S., L.R.C.P.Lond.,
Assistant Surgeon to the Clayton Hospital and Wakefield General Dispensary.

TUBERCULOSIS IN CHILDREN.

THE following passage, which you quote from the annual report of the Chief Medical Officer of the Board of Education,[1] is full of meaning: "In early childhood lymphatic tissue, bones, and joints are more frequently invaded than the lungs, and although infection of the lungs appears to become increasingly common as the child grows older, it

[1] BRITISH MEDICAL JOURNAL, p. 555.

comparatively seldom presents a similar picture to the well known pulmonary tuberculosis of adult life.' Although I examine a large number of school children yearly, I have never yet met with a case presenting "a similar picture to the well known pulmonary tuberculosis of adult life." During routine examination I see very many cases presenting signs of infection of the bronchial glands, and one is tempted to put all these in the same category with infected glands in other parts of the body. The clinical signs presented by a child suffering from tuberculous glands of the neck are identical with the symptoms present in a case of infected bronchial glands, except that in the latter we get pressure within the thorax giving distinctive signs. I venture to make the proposition that primary pulmonary tuberculosis in the child of school age is very rare, and the cases we see simulating pulmonary tuberculosis are in reality infections of the bronchial glands, and that the lung lesions in these cases are secondary to and part of a general glandular infection, probably caused by the tubercle bacillus of bovine origin.

Beverley. T. READMAN.

Reviews.

THE NEW ANATOMY.

ANY one who is watching the progress of anatomy in Britain must have noted a very definite change—almost a revolution—in the outlook of our younger anatomists. No better evidence as to the nature and degree of the change that is coming could be found than in the *Clinical Anatomy of the Gastro-intestinal Tract*[1] by Professor WINGATE TODD, just issued by the Manchester University Press.

It is true that Professor Todd occupies the chair of anatomy in one of the universities of the United States, but every page of his book proclaims him to be a British anatomist of the younger school. It is not difficult to define the nature of the changes which are taking place in our dissecting-rooms. The older school studied and described the *dead* human body; the aim of the newer school is to study and teach the anatomy of the *living* body. Many will remember the black, dried, inflated, hardened stomachs and the blown-out parchment caeca with membranous gaping ileo-caecal lips on which we were asked to base our knowledge for a career in the practical application of surgery and medicine. Then came a "formalin" period in anatomy, in which the conception of anatomical forms underwent a change, but in the opening years of the formalin period the anatomist's point of view remained centred on the various forms seen after death. The discovery of Roentgen rays was the factor which ultimately killed the dead, unimaginative study of the human body. In his description of the viscera of the abdomen Professor Todd has used his knowledge of the living viscera as revealed by the use of *x* rays. The student and practitioner will feel as they read the pages of Professor Todd's book that the anatomist has at last got a glimpse of the world of clinical endeavour that lies beyond the doors of the dissecting-room.

Another change that has come across the anatomical mind is to be noted. The teachers of a former day were inclined to regard the study of anatomy, not as the basis of medicine, but as an end in itself. There were so many tempting paths which led into the unlimited realms of comparative anatomy and embryology, and along these paths teachers often guided their willing students without any thought as to the ultimate aim a medical student had in view. It must not be thought that the younger anatomist does not make excursions into such collateral subjects; one finds that Professor Todd often does, but for the same reason as John Hunter—namely, to find living facts that help the medical student and the medical practitioner to understand the mechanism of the living human body. Comparative anatomy can throw a flood of light on obscure structures like the appendix vermiformis.

Perhaps the most remarkable change in the outlook of the anatomist is the change in his attitude towards his colleagues—the physiologist and pathologist. Professor Todd has used the discoveries of the physiological and pathological laboratories to the full in explaining the anatomical problems of the alimentary tract; he also shows a wide and accurate acquaintance with medical and surgical literature—a knowledge which is absolutely essential for one who is to help in the education of new generations of medical students. We can recommend Professor Todd's book to medical students as the best clinical manual on the anatomy of the alimentary tract and as an exemplar of how anatomy should be studied and taught.

[1] *The Clinical Anatomy of the Gastro-intestinal Tract.* By T. Wingate Todd, M.B., Ch.B., F.R.C.S.Eng. Manchester: The University Press. London, New York, etc.: Longmans, Green, and Co. 1915. (Cr. 8vo, pp. 276; 32 figures. 6s. net.)

EXPERIMENTS ON ANIMALS.

DR. W. W. KEEN is well known to his profession in this country as one of the very foremost of the great American surgeons. He has enjoyed, over here, that sort of distinction, that welcome, which were given to Lowell. And his book, *Animal Experimentation and Medical Progress*,[2] has distinction and high authority. None of us could desire a better summary of the evidence, to put into the hands of anybody who still doubts that experiments on animals are of absolute necessity for the advancement of the work of our profession.

The book is a collection of many papers and addresses by Dr. Keen, dating from 1885 to 1913. Thus, it is not only a system of evidence—it is also an account of antivivisection in the United States. On this point we have only to say that antivivisection in the United States seems to be even worse than it is here—more false, more unscrupulous, more wild in its charges of cruelty. It could not have a more gentle, polite, and patient opponent than Dr. Keen; indeed, we may wonder that he takes to heart so anxiously the extravagant statements of a few American antivivisectionists. But that is not our affair; the opposition in our own country is well-nigh silent now, in these grave times; and let us hope that it will not for many years after the war regain any hold on public attention. We can now well leave it to itself.

The historical part of Dr. Keen's book—the tracing of the great discoveries, the explanation of the ways and purposes of research, and the study of the rise and influences of bacteriology—are admirable. He writes very quietly, with a most delightful style, and he writes with that insight which comes of life-long experience in great practice.

To complete the value of this very valuable book, there is an introduction by one of the most illustrious of living Americans—Dr. Eliot. None of us in this country who read what Dr. Eliot wrote of the ethical or spiritual purposes of the present war, will doubt his authority to teach ethics; and in this introduction he says of the ethics of experiments on animals all that needs to be said, and with an authority and dignity that must carry conviction to all unprejudiced minds.

We very heartily commend this book not only to all medical men who would like to have the evidence at hand for their own use, but to all non-medical readers. It would be hard to find a more useful book on the subject.

[2] *Animal Experimentation and Medical Progress.* By W. W. Keen, M.D., LL.D. With an introduction by C. W. Eliot, LL.D. Boston and New York: Houghton Mifflin Co. 1914. (Post 8vo, pp. 332.)

MEDICAL WOMEN AND THEIR WORK.

ONE result of the war will probably be a considerable extension of the field of practice now open to medical women. In his presidential address to the General Medical Council on June 1st, Sir Donald MacAlister said that the services of medical women had been freely offered and accepted for many of the places now vacant at home. In a book, to which Mr. Stephen Paget has contributed an introduction, Miss A. H. BENNETT[3] gives a brief and readable account of the struggles by which a few determined women battered down the portals of the profession which were closed to them till less than half a century ago, and opened up a new career for their sex. Repulsed at Edinburgh, they were more successful in London, where the School of Medicine for Women was founded in 1874. But the battle was not yet won. The Medical Qualifications Act of 1876 threw open the medical profession to women, but the qualifying bodies only gradually abandoned their obstructive attitude. Although Mrs. Garrett

[3] *English Medical Women: Glimpses of Their Work in Peace and War.* By A. H. Bennett. With a preface by Stephen Paget, F.R.C.S. London: Sir I. Pitman and Sons, Ltd. 1915. (Cr. 8vo, pp. 167; 3 illustrations. 3s. 6d.)

empties the glands and ducts of gonococci which constitute the plugs of muco-pus I described as filling the catheter perforations.

Having varied the circuiting and tried current reversals during the last three years of work at gonorrhoea, I believe the system I described to be the best. Still, I endeavour to keep an open mind until more is known of bacterial movements and vitality in relationship to the inflamed membranes or tissues which so many of us are trying to heal.—I am, etc.,

London, W., June 21st. CHARLES RUSS.

THE DISCOVERY OF CHLOROFORM.

SIR,—Permit me to add a few facts in support of your views on the claims made on behalf of Waldie to be considered the discoverer of chloroform. In 1886 I put forward the claim of Samuel Guthrie of Sacketts Harbour, then an important naval base, where he resided, and as a surgeon in the Army of Independence acted as consulting chemist to the munitions department. Guthrie was a regular contributed to *Silliman's Magazine*, then the principal scientific monthly in the United States of America, and in volumes xxi and xxii he published his articles on a new method of preparing solution of chloric ether. This paper appeared ten years prior to C. W. Long's discovery of the anaesthetic properties of ether and long before J. Y. Simpson sought a substitute for the ill-smelling ethyl oxide. Guthrie's other papers consisted of "Chemical fulminating preparations," "Vapourization of mercury," "Sugar from potato starch," and "On oil of turpentine."

He is credited with not alone discovering chloroform, but also with being the first to use it medicinally.—I am, etc.,

Dublin, June 21st. GEORGE FOY.

DESTRUCTION OF LICE AND OTHER BODY VERMIN.

SIR,—I have read Dr. J. Parlane Kinloch's admirable article in the JOURNAL of June 19th with very great interest. I am commandant of the 7th Northumberland Voluntary Aid Hospital, where patients are taken in from the local "billets," often in a verminous condition, and I write to beg that Dr. Kinloch would be so good as to make a suggestion as to how best to deal with the condition in the most economical way. It would be sufficient for my purposes if I could "disinfect" the kit of only one man at a time, and it would appear that the provision of a dry-cleaning bath and extractor would be unnecessarily expensive; yet I wish to use petrol rather than any other agent, as it is easily obtainable here, and its use would not require that the clothes (uniform particularly) should be dry-cleaned afterwards, as is the case, I understand, after using the phenol derivatives; indeed, to use the latter would necessitate some appliance to raise the temperature to 65° C., which we do not possess.—I am, etc.,

Monkseaton, Northumberland, June 22nd. H. E. DAVISON.

Obituary.

SURGEON-GENERAL ARTHUR JAMES PAYNE, of the Bengal Medical Service (retired), died on May 21st, aged 88. He was born on October 21st, 1826, the son of Quartermaster Payne, of the Grenadier Guards; educated at King's College, London, took the diploma of M.R.C.S. in 1847, and the degree of M.D.Lond. in 1848. He was also B.A. of London University. He was nominated an assistant surgeon in the I.M.S. on December 20th, 1848, became surgeon on February 1st, 1863, surgeon-major on December 20th, 1868, and deputy surgeon-general on September 13th, 1879, retiring with a step of honorary rank on February 1st, 1885. After serving in the artillery for a short time after his arrival in India, in 1849, he entered civil employ in the North-West Provinces, and was civil surgeon of Fatehgarh and Gorakhpur in 1850–52. In 1852 he reverted to military duty, and on December 27th, 1855, was appointed garrison surgeon of Fort William, and spent the whole of the rest of his thirty years' service in Calcutta. On October 31st, 1856, he entered civil employ in Bengal, as second assistant surgeon of the Presidency European General Hospital, and in 1863 was appointed superintendent of the Calcutta lunatic asylums, holding that post till his promotion to the administrative grade in 1879. In 1880 he became administrative medical officer of the province of Bengal, with the local rank of surgeon-general. Though he was serving in India during the Mutiny, the *Army List* assigns him no war service. At the time of his death he was third in seniority of the retired officers of the Bengal Medical Service, after Surgeon-Majors H. B. Hinton and W. F. Mactier.

LIEUTENANT-COLONEL MONTAGUE STOKES EYRE, Madras Medical Service (retired), died at Bath on May 29th. He was educated at Edinburgh University, where he took the M.B. and C.M. in 1876, and entered the I.M.S. as surgeon on September 30th, 1876, becoming surgeon-major on September 30th, 1888, and surgeon-lieutenant-colonel on September 30th, 1896. He retired on April 7th, 1907. Though most of his thirty years' service was spent in military employ, the *Army List* assigns him no war service. He was the second son of the late Edmund Walter Eyre, Inspector-General of Hospitals, Madras.

LIEUTENANT-COLONEL GEORGE TURNER TREWMAN, R.A.M.C. (retired), died suddenly on June 13th, aged 59. He was born on September 12th, 1855, the eldest son of the late Rev. Arthur Peile Trewman, vicar of Ilminster, Somersetshire, educated at Westminster Hospital, and took the diplomas of L.S.A. in 1876, and of M.R.C.S. in 1878, and the degree of M.B.Durh. in 1879. He entered the army as surgeon on July 30th, 1881, became surgeon-major on July 30th, 1893, lieutenant-colonel on July 30th, 1901, and went on half-pay on March 17th, 1904. He retired on August 3rd of the same year, but had been re-employed during the war. He served at Suakin in the Soudan campaign of 1885, and received the medal with a clasp, and the Khedive's bronze star.

MAJOR ARTHUR TREGELLES PRIDHAM, Indian Medical Service, died suddenly on June 6th. He was the second son of the late Arthur E. Pridham of Plymouth, and was born on August 4th, 1877. He was educated at St. Bartholomew's Hospital, and took the diplomas of M.R.C.S. and L.R.C.P.Lond. in 1899, and graduated M.B.Lond. in 1900, in which year he obtained the Brackenbury medical scholarship. After acting as house-physician at St. Bartholomew's and at the Queen's Hospital for Children, Hackney Road, he entered the I.M.S. as lieutenant on September 1st, 1902, becoming captain on September 1st, 1905, and major on September 1st, 1914. He was appointed medical officer of the 8th Gurkha Rifles in 1907, and in 1912 went into civil employ in Burmah as Superintendent of the Rangoon Central Gaol, but had been on sick leave since October 6th, 1913. He served in the Abor campaign on the North-East frontier of India in 1911–12, and received the medal with a clasp.

The Services.

TERRITORIAL FORCE.

EXCHANGES OF MEDICAL OFFICERS.

CAPTAIN J. M. POSTLETHWAITE, 1st East Lancashire Field Ambulance (T.F.), whose request for an exchange was published in the JOURNAL of May 1st, asks us to state that, as he is now at the front on active service, an exchange is no longer desired, and in any case would be difficult.

Universities and Colleges.

VICTORIA UNIVERSITY OF MANCHESTER.

THE following candidates have been approved at the examination indicated:

M.D.—J. S. B. Stopford (awarded gold medal), G. C. Mort.

IN the three weeks ending June 19th, 19 cases of plague with 17 deaths were reported at Hong Kong. In Mauritius there was one fatal case of the disease on June 14th

Medical News.

WE regret to learn that Mr. Howard Marsh, Master of Downing College, Cambridge, and formerly surgeon to St. Bartholomew's Hospital, died on June 24th.

DR. WILLIAM MURRAY DOBIE of Chester left estate of the gross value of £6,006, with net personalty £3,851.

MR. A. H. TUBBY has been elected an Honorary Member with Medal of the First Class of the Società Fisico-Chimica Italiana.

THE Civil List pensions for 1914–15 include a pension of £150 to Dr. Charlton Bastian, F.R.S., in consideration of his services to science.

THE names of the following gentlemen have been added to the Commission of the Peace for Perthshire: David G. Donaldson, M.D., Dunning, and John Irvine, M.D., Muthill.

MAJOR LEONARD DARWIN, President of the Eugenics Education Society, will open a discussion on alcoholism and eugenics at the meeting of the Society for the Study of Inebriety, to be held in the rooms of the Medical Society of London, 11, Chandos Street, W., on Tuesday, July 13th, at 4 p.m.

BRITISH nurses who may be desirous of offering their services to Italy are recommended to communicate with Miss Snell, Matron of the Scuola Convitto Regina Elena, Policlinico, Rome, who would be glad to give advice as to the way in which such help can be put into the best channels.

THE annual general meeting of the Poor Law Medical Officers' Association of England and Wales will be held on Tuesday, July 6th, in the Council Chamber of the British Medical Association, 429, Strand, London, W.C., at 4 p.m. All Poor Law medical officers are cordially invited. Tea will be provided.

THE annual general meeting of the Research Defence Society will be held at the house of the Royal Society of Medicine, 1, Wimpole Street, Cavendish Square, W., on Wednesday, June 30th, at 5 o'clock. In the absence of the President, Lord Lamington, on military service, Major-General the Hon. Sir Reginald Talbot, K.C.B., will take the chair. The report will be presented by Lord Knutsford, Chairman of Committee. Other speakers will be Sir William Osler, and Surgeon-General Sir Alfred Keogh, K.C.B. After the meeting Dr. Andrew Balfour, C.M.G., will give a demonstration, with the cinematograph, on the protective treatment against typhoid fever and cholera.

IN a paper read before the Royal Meteorological Society on June 16th by Mr. C. Harding, some support was given to the belief that artillery fire may have some effect on the rainfall. From the beginning of the war until the middle of October the weather conditions in the western area of operations were bright and dry with occasional short spells of rain, but from the middle of October to the end of February rainy and rough weather continued with little cessation. In the British Isles the rainfall for the nine months ending April, 1915, was below the average in the north and west, but greatly in excess of the normal in the south and south-east. The rainfall was also in excess at all western Continental stations. Mr. Harding, while not suggesting that the rainy conditions were generated by gun firing, thinks it quite possible that at times, when the conditions were favourable to rain, the rains may have been augmented or accelerated by the concussion initiated over the battle grounds.

THE Central Midwives Board met on June 17th. A letter from the Midwives Institute was read relative to the decision of the High Court in Stock *v.* Central Midwives Board. The Board's reply is: "That the decision of the High Court in the case of Stock *v.* Central Midwives Board, although reversing the decision of the Central Midwives Board to remove the name of the midwife from the Roll, confirms the Board in its position as the authority which determines what is and what is not misconduct in a midwife, and decides that misconduct is not to be limited to misconduct in a professional sense; the Board has held that conduct which, before enrolment would render it impossible to certify that a candidate was "of good moral character" renders her, after enrolment, liable to be removed from the Roll for 'misconduct,' and there is no likelihood that the Board will depart from this position." Recognition as lecturers was granted to Drs. Arthur Crook, G. F. Odhams and Herbert Edward Taylor, M.D., and approval to undertake the practical training of pupils to two certified midwives.

Letters, Notes, and Answers.

THE telegraphic addresses of the BRITISH MEDICAL ASSOCIATION and JOURNAL are: (1) EDITOR of the BRITISH MEDICAL JOURNAL, *Aitiology, Westrand, London*; telephone, 2631, Gerrard. (2) FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Articulate, Westrand, London*; telephone, 2630, Gerrard. (3) MEDICAL SECRETARY, *Mediseera, Westrand, London*; telephone, 2634, Gerrard. The address of the Irish office of the British Medical Association is 16, South Frederick Street, Dublin.

QUERIES.

MEDICAL ATTENDANCE AT PRIVATE SCHOOLS.

A SCHOOL DOCTOR writes: May I ask the readers of your JOURNAL, especially those who have schools under their charge, if it is customary to give a 10 per cent. discount on their accounts against schools? Such an application has been made to me. To quote from the letter: "The head master is not anxious to press this, but as it appears to be the custom in other schools he thought you would be willing to grant the 10 per cent. which appears to be the usual amount allowed."

ANSWERS.

BREATHING EXERCISES.

DR. G. E. SHUTTLEWORTH (London) writes, in reply to "A. D.," that a serviceable sheet, entitled *Breathing Exercises*, by Duncan Matheson Mackay, M.D., is published by Messrs. Bale, Sons and Danielsson, Great Titchfield Street, W., price 1d.

PARTNERSHIP AGREEMENTS.

A.M.S.—(1) We have never known of an agreement in a medical partnership in which the share of one of the partners on his demise lapsed for the benefit of the surviving partners. If such a windfall were to take place, on general principles it would be divided among the survivors in proportion to their respective shares in the partnership. (2) If, in a partnership of three, B. and C. paid out A., and then sold A.'s share to another, the purchase money would be divisible among B. and C. in the same proportion as the amounts respectively found by B. and C. in paying out A. As the firm would pay out A., these amounts would be usually in proportion to the respective shares of B. and C. in the partnership.

LETTERS, NOTES, ETC.

BODY VERMIN.

DR. W. LYLE (Newtownstewart) writes: I have found that boiling the under garments for half an hour, then drying, and afterwards steeping in a 1 in 1,000 solution of corrosive sublimate, and allowing them to dry, will destroy body lice and free patients from a recurrence under ordinary conditions for several months. This has been my treatment in private practice for several years in cases of old patients suffering from these distressing pests, and I have found it invariably successful.

VITAMINES AND PASTEURIZED VERSUS CLEAN RAW MILK.

DR. JAMES OLIVER (London) writes: Your very excellent leaderette in the JOURNAL of May 29th, p. 938, on "Vitamines," raises the important question of the relative values to life of pasteurized and clean raw milk, when fed more especially during infant life, seeing that pasteurization lowers if it does not actually annul the value of milk vitamine. We are all so familiar with milk that we fancy we know a very great deal about its health-giving qualities and can pasteurize it with impunity, and yet it is only during the last few years that we have become aware that it contains a substance known as vitamine, and that there is in milk a considerable amount of volatile sulphur. Now, unfortunately, by the process of pasteurization these two very valuable substances are practically expunged from milk and other very essential mineral substances are so chemically altered that they no longer fulfil their due physiological functions in our bodies when pasteurized milk is fed. It is thus and in a host of other ways that the resisting powers of our bodies are being lowered, and we are being rendered more susceptible to various different diseases. Paradoxical though it may seem, the more we struggle to live the more we tend to die.

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