had generally to be given, and in such debilitated cases the diet had necessarily to be bland, nourishing, and readily assimilable; it consisted of milk, milk and eggs, meat essences, milk puddings, and light soups. Convalescence in these cases was prolonged, and return to normal dietary had to be carefully regulated.

Case 5.

Dhooly bearer, admitted on August 6th, 1917, with diarrhoea and debility, and a history of several weeks of ill health, abdominal pain, and the passing of mucus with the stools. He was passing from sixteen to twenty stools daily, was very weak and emaciated, and could scarcely articulate. He had continued on duty till forced by weakness to seek medical aid. Liver and spleen not palpable. Temperature 99° to 100°. Pulse very rapid and weak. Tongue furred, dry, and protruded with difficulty. Lungs showed poor air entry and signs of old pleurisy. He was at first considered to be a case of phthisis, with diarrhoea, but no tubercle bacilli could be detected in the sputum. Blood was negative as regards malaria. Examination of stools showed at first no amoebae, but on August 10th there was a little blood and mucus in the stool, and amoebae were then found. He was at once put on emetine hypodermically, in doses of 1 grain daily, and on August 13th, when the symptoms had improved and his general condition was better, 2 grains of emetine and bismuth iodide were given in the evening to supplement the emetine. The former drug was well borne and caused no vomiting. By August 15th there was slight improvement, but the patient was still very weak and depressed, and was passing five or six stools a day. On August 17th he was much better, and there was no blood and mucus in the stools, and the emetine was discontinued. On August 19th the stools contained neither amoebae nor cysts, but the emetine and bismuth iodide was now given in 2 grain doses twice daily. The appetite had returned and the patient commenced to pick up. Medicinal treatment was stopped on September 1st, after a total of 9 grains of emetine and 40 grains of emetine and bismuth iodide had been given. A few days later the patient was transferred convalescent to another hospital.

This case is a very fair illustration of the action of emetine and bismuth iodide in severe amoebic dysentery in debilitated subjects.

No mention has been made of enemata, and, in fact, very little use was made of that method of treatment. In the milder cases it did not appear called for, and in the severe type, similar to that last described, it seemed to be a highly dangerous proceeding, considering the state of the bowel in these cases, as seen *post mortem*. Appendicostomy or caecostomy was not attempted, as the cases were too debilitated to stand operative interference, and the symptoms appeared to be relieved to a great extent by medication.

CONCLUSIONS.

Judging by the results in this small series of cases, it would seem:

1. That we have in emetine and bismuth iodide a combination of considerable potency in the treatment of amoebic dysentery, particularly when the amoebae are assuming their resistant stage. When given in pill form in doses not exceeding 2 grains its emetic effects are slight, at all events in Indian cases. Its use in conjunction with hypodermic injections of emetine hydrochloride in acute amoebic dysentery would seem to be beneficial, in that convalescence is established earlier, and patients are less likely to become "carriers." It cannot be considered in the light of a substitute for emetine, as attempts to treat acute cases with it alone ended in failure, until emetine was used in addition.

2. In "carriers," and in those convalescents who continue to harbour cysts, emetine and bismuth iodide should prove superior to emetine, and it would seem a wise proceeding, from a public health point of view, to subject all cases of amoebic dysentery to a course of emetine and bismuth iodide during convalescence.

I wish to express my grateful thanks to Colonel W. H. Willcox, C.B., A.M.S., Consulting Physician to the Forces in Mesopotamia, for his kind and valuable advice and help in the treatment of the cases and the compilation of these notes, and also to my indefatigable assistant, Sub-Assistant-Surgeon Bashi Ram, without whose intelligent aid and knowledge of the vernacular the cases could not have been systematically treated or noted.

THE new edition of the *Practice of Medicine* by Sir Frederick Taylor, which is about to appear, will contain articles on trench fever, so-called soldier's heart, trench frostbite, and T.N.T. poisoning. The text has been subjected to thorough revision throughout and much new matter introduced.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

THE STERILIZING OF HYPODERMIC SYRINGES.

A Laboratory Note.

MOST of the hypodermic syringes now in use either have a glass barrel and metal piston, or are all glass. Nowadays, in addition to serum and vaccine injections, a number of drugs are used hypodermically, and the syringe is in very frequent demand.

The usual method of sterilizing is by boiling in a small steamer or saucepan. It takes a few minutes, and fine hypodermic needles soon become blocked by rust and their sharp points blunted; and, further, it must be remembered that the spores of some bacteria are not quite killed even by temperatures of 100° C. Disciples of Sir Almroth Wright use hot oil at a temperature between 130° and 140° C., which, besides being a more effective sterilizer than boiling in water, keeps syringe and needles in better working order. I am told that paraffin is better than olive oil.

In searching for a simpler and more convenient method I made tests with a compound consisting of lysol, ether, and methylated spirit:

Lysol	...	...	...	...	mxv
Etheri sulph.	...	...	...	...	ʒij
Methylated spirit	...	...	...	ad	ʒj

Syringes of various sizes, 1 c.cm., 2 c.cm., 5 c.cm. and 20 c.cm., were filled with broth cultures of mixed bacteria, including staphylococci, *B. coli*, *B. proteus*, diphtheroids, and *B. subtilis*. They were then emptied, and each in turn sterilized by inserting the needles into the lysol-ether-alcohol mixture, and drawing it up into the syringe two or three times, care being taken that the mixture reached the whole interior surface of the barrel. The syringes were half filled with the fluid, and shaken up for a few seconds with the piston fully withdrawn, and the contents then returned to the bottle (for the same fluid will do over and over again until it becomes very turbid, and begins to choke the finer needles). After this procedure sterile glucose broth was drawn into each syringe, shaken up in it for five seconds, and then incubated for a week. In some of the earlier experiments in which the lysol content was below 1.5 per cent., it was found that though the 1 c.cm. and 2 c.cm. syringes were sterile, the 5 c.cm. and 20 c.cm. syringes yielded a few colonies of *B. subtilis* and *B. proteus*; lysol 3 per cent. appears to be rapidly effective. Ether was used as one of the diluents to enable the lysol more readily to penetrate oily or fatty particles which might have obtained access to the interior of the syringes, and alcohol to prevent rusting of the needles. I have used this method of sterilizing syringes several hundred times in giving hypodermic injections without a trace of inflammation at the site of puncture. An ounce bottle of this solution does not take up much room, or may be stowed away in the waistcoat pocket.

I have found it useful and thoroughly trustworthy for sterilizing the skin before taking blood from a vein for culture tests. Its penetration is superior to tincture of iodine, and it does not irritate delicate skins if it is only left on a very short time—for example, ten seconds. I then swab over the area with plain methylated spirit to prevent any chance of vesicating by the lysol. Surgeons therefore should find it useful in their emergency bags for rapidly sterilizing instruments, skin of patients, or their own finger-nails if without their aseptic kits and rubber gloves.

London, W. H. LYON SMITH.

NASAL OBSTRUCTION AS A CAUSE OF HUNGER.

THE following case presents certain features of interest. The patient, a man of 40, asked me if I could explain why he was always thinking about food, and was sometimes voraciously hungry without cause. On going carefully into his case I could find no abnormality beyond a deflected septum with narrowing of the left nostril. I relieved some of the blockage by painting the inside of the nose with a weak solution of cocaine. As soon as the passage was clear he said: "Now I can read my book; my mind no longer dwells on dinner." The voracious appetite usually came on at a meal, when he stooped over the

table reading a book, and was increased by eating. It was associated with swelling and redness of the nose, extreme restlessness, and a loss of brain power. I found that this train of symptoms never arose unless the left nostril was seriously blocked.

Some light seems to be thrown on the case by a passage from Purves Stewart's *Diagnosis of Nervous Diseases*, in which he says: "A certain amount of clinical evidence supports the view that there is a special cortical centre associated with the sensations of hunger and thirst. It would appear to be in the temporal lobe at or near the olfactory centre." With regard to the constant "dreamy" feeling complained of by the patient, I found in the same work: "Disease of the tip of the temporal lobe causes a sudden subjective sensation of smell or taste (often associated with a characteristic 'dreamy' mental state)."

I found no evidence of disease of the temporal lobe in my patient. He refused operation for the deflected septum, but I cured him of his attacks of acute blocking by getting him to exercise his alae nasi muscles. A week's exercise in front of the glass gave him well arched nostrils with disappearance of the subjective symptoms, particularly the dreamy mental state.

CHARLES J. HILL AITKEN, M.D.

THE PHENOMENA OF PURULENT BRONCHITIS.

A SUSPICION arises that many cases which we have hitherto classed as pneumonia of a peribronchial type were really instances of purulent bronchitis. These patients had a very rapid pulse, exceedingly frequent respiration, painful whistling cough, high temperature, headache, profuse expectoration, sometimes purulent, sometimes prune-juice-like. They—or at least the worst of them—had a heavy heliotrope hue of the lips and even of the face. The clinical signs of pulmonary consolidation were indeed sometimes wanting, but the patients were so weak and distressed by movement that one hesitated to harass them by too frequent examinations, and the rapidity of pulse and respiration seemed to justify a diagnosis of pneumonia.

It is suggested that the lesion is really pneumococcal infection supervening on influenza, and that it is infectious. Post-influenzal pneumonia is so convenient and generally accepted a diagnosis that we are tempted to put the label on many doubtful cases, but I submit that the disease is due to a mixed infection—rather an acute pneumococcal septicaemia than a mere pneumonia following influenza. The cases which have been under my care were all of a mixed infection but not necessarily influenza. They were in patients who had had malaria, dysentery, or some form of sepsis. None of the fatal cases were very young. Their lungs were not absolutely free from solid patches, but the parts chiefly affected were the bronchioles, from which grey frothy pus exuded.

The affection is far more fatal than ordinary pneumonia, and the influenzal type is generally contagious, hence the necessity for early diagnosis and isolation treatment. Stimulants freely, with oil of wintergreen externally, and stimulating expectorants combined with nux vomica and gum resins seem to be useful.

J. C. MCWALTER, M.D., F.R.F.P. and S.Glasg.

Dublin.

SYPHILIS INSONTIUM.

As an example how syphilis may be contracted through no fault of the patient, I wish to record the case of two officers who were attended by the same barber in the army somewhere in France. The barber had a sore on his hand which proved to be of syphilitic origin. Both officers developed a rash in due course, and the army doctor diagnosed secondary syphilis, confirmed by a positive Wassermann reaction. One of the officers became a patient of mine, and an independent Wassermann test was positive. I may add that the trouble in my patient's case started on his scalp as a sore.

London, S.W. N. WALMISLEY.

THE French Government has issued an urgent appeal for the cultivation of the castor oil plant in all suitable localities. It is made not in the interests of pharmacy, but because castor oil is the best lubricant for air engines. The oil was formerly obtained chiefly from South America, but the amount imported is now small. The plant will grow in sheltered situations where it is not exposed to late frosts or rough winds. It is raised from seed, the seedlings being set out about two yards apart.

Reviews.

OBSERVATION AND COMPILATION IN SURGERY.

THE accidents of transport in these days bring together for review two books which present a striking contrast that may perhaps be considered typical of much. The one is a sound piece of clinical observation and deduction, the other a compilation demonstrating once more by its very pretentiousness the German professor's incapacity, when left to his own resources, of throwing any useful light on new problems.

Criticism of the volume on the peritoneum in war surgery,[1] by MM. STASSEN and J. VONCKEN, is disarmed by a foreword of the authors, who wrote in an advanced hospital on the Yser, far from books and without opportunity for laboratory research. But, indeed, the essay calls not for criticism; assuredly not from those who in like circumstances have painfully learnt similar lessons without, maybe, the industry to make a faithful record of their errors and misfortunes, or the candour to describe the tragic steps leading to a settled policy in the face of abdominal wounds. Here we find, well documented by case records, an account of the "false abdomen," the "doubtful case," the extraperitoneal visceral lesion, the parenchymatous-organ solus, the hollow viscus injury, the haematoma, infection. We follow the authors in their recognition of peritonism, simulating true intraperitoneal wound so closely as to be differentiated in the end only by the absence of some one—any one—of all the signs present together in the latter; of genuine wounds devoid of symptoms; of the necessity for sending to the special hospital every wound that *might* by any chance lead to the abdomen, and especially all those of the upper part of the thighs and the buttocks. We find them at last coming to the decision that in every case the wound should be excised in such a way that the track can be followed right to the peritoneum—and further if need be. To those going fresh to work in a casualty clearing station we commend the study of this book from cover to cover; there is hardly a page which does not disclose an experience or an observation that must be familiar to those who have operated in an advanced abdominal centre, and few, we think, who, even if they do not always agree with the authors, will not admit that these Belgian surgeons have fulfilled their hope and written "*un livre de bonne foy.*"

A textbook of war surgery,[2] a thousand pages long, written by a score or more of the best-known German surgeons, and published after two years of war experience, should prove of great interest, but it does not. Is it that the Censor has cut out all the epoch-making discoveries of Teuton surgeons lest the enemy should profit? or can it be that Teuton surgery has made no extraordinary contributions to the solution of problems common to them and to us? In favour of the former hypothesis there is a notable absence of any reference to a prophylactic for gas gangrene, though there has been some reason, in the greater resistance of the Boche, wounded in like conditions with our own men, to infer or surmise its existence. Be that as it may, the deeper one plunges into this volume the clumsier it appears—clumsy in arrangement, clumsy in attitude of mind, clumsy in treatment. There is little or nothing here to be extracted for the instruction of our M.O.'s in the field or the betterment of their methods. If we turn to any chapter at hazard we find this. The section on the abdomen is from the pen of Schmieden himself, and it is full of good clinical observation, by no means lacking in descriptive power, but it smacks of Halle, not of the front. The real problems of gut injuries through the buttock, the back, the thorax, receive no proportionate share of attention, and the details of technique, from the author of a textbook of operative surgery, are meagre. It is the same with the chest, with the head, with other regions. Fresh from dealing with such work behind the lines one seeks guidance on knotty points, only to be disappointed. Take, again, the question of fractures of the femur; assuredly the British army has nothing to

[1] *Le péritoine en chirurgie de guerre: Etude clinique.* By MM. Stassen et J. Voncken. Paris: Baillière et Fils. 1917. (Roy. 8vo. pp. 160.)

[2] *Lehrbuch der Kriegs-Chirurgie* Edited by A. Borchard and V. Schmieden. Leipzig: Johann Ambrosius Barth. 1917. (Roy. 8vo. pp. 988; 5 plates, 429 figures.)

THE BELGIAN DOCTORS' AND PHARMACISTS' RELIEF FUND.

SUBSCRIPTIONS.

THE following subscriptions to the Fund have been received during the week ending Wednesday, January 23rd:

	£	s.	d.		£	s.	d.
Dr. R. J. Wilson	2	2	0	Sir Thomas Barlow ...	5	0	0
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Subscriptions to the Fund should be sent to the treasurer of the Fund, Dr. H. A. Des Vœux, at 14, Buckingham Gate, London, S.W.1, and should be made payable to the Belgian Doctors' and Pharmacists' Relief Fund, crossed Lloyds Bank, Limited.

Universities and Colleges.

CONJOINT BOARD IN SCOTLAND.

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FINAL EXAMINATION.—*Surgery:* H. Miller. *Midwifery:* H. Miller, E. Spence. *Medical Jurisprudence:* J. J. van Niekerk, J. M. Speirs, L. L. Steele, W. B. Watson, B. Chiefitz, V. A. Rankin, A. Galustian, J. C. Meek, J. K. Steel, S. A. Faulkner.

The following candidates having passed the Final Examination have received the diplomas of L.R.C.P.E., L.R.C.S.E., L.R.F.P. and S.G.:

W. O'G. Donohue, C. R. C. Moon, Arukatti Patabendigo Frederick Abeysuriya.

Obituary.

HAROLD FREDERIC MOLE, F.R.C.S.,

SURGEON TO THE BRISTOL ROYAL INFIRMARY.

MR. HAROLD F. MOLE, F.R.C.S., died at his residence, 24, College Road, Clifton, on December 21st, 1917, from heart failure following asthma, to which he had been subject since childhood. For many years his brilliant professional career had been seriously handicapped by ill health, but he never allowed this to interfere with the excellence of any work he undertook.

After studying at the Bristol Medical School and Royal Infirmary, where he was awarded the Tibbits Memorial Prize for practical surgery, he took the diplomas of L.R.C.P., M.R.C.S. in 1890, and that of F.R.C.S. in 1892. In 1891, after holding junior appointments at the Royal Infirmary, he became curator of the museum, the post being created by the staff in order to retain him as a colleague. From 1895 to 1902 he was in turn house-physician, house-surgeon, and senior resident officer, in which capacities he proved himself an astute clinician and a tactful administrator, and became very popular with the students as a clinical teacher. In 1902 he was elected assistant surgeon, with charge of the aural clinic. His knowledge of otology soon became very thorough, and he did extremely good work in the production of a series of models of the labyrinth with fusible metal. He joined the Otological Society in 1903, and remained a member of the section after the amalgamation with the Royal Society of Medicine, and later he was made member of the council.

Considering his state of health, the amount of energy he displayed was wonderful, and he found time to act as secretary to the Bristol Medico-Chirurgical Society from 1903 to 1907, to the journal of which society he made several contributions. In 1909 he became full surgeon to the infirmary and clinical teacher in surgery to the university, and continued as such until 1916, when ill health compelled him to relinquish these posts.

None who came in contact with him could fail to be attracted by his personality. Punctual in habit and precise in action, he combined a cultured mind and a keen sense of humour with a rare appreciation of his responsibilities, which rendered him a charming companion and an exceptionally valuable member of the profession.

It was a bitter disappointment to him that in 1914, owing to illness, he had to resign his commission in the R.A.M.C.(T.F.), after serving for two months. He married in 1913, and leaves a widow and two sons.

A. L. F.

DR. GEORGE KILPATRICK GIVEN died at his residence at Muswell Rise on January 6th, aged 71. He received his medical education at the Ledwich School, Dublin, and Queen's College, Belfast, and took the diplomas of L.R.C.P. and S.Edin. in 1869 and the L.M.Dub. He practised for many years at Gortin, co. Tyrone, where he was physician to the Infirmary and Fever Hospital, M.O.H. to the Gortin Dispensary District, and consulting M.O.H. to the Gortin Union. He was also a magistrate for county Tyrone. He had been in failing health since the loss in March, 1915, of his youngest son, who was on board the ss. *Falabar* when she was torpedoed. He leaves a widow, one son, who holds an appointment as staff surgeon in the Royal Navy, and one daughter.

DR. HERBERT WHITLEY SKEY WILLIAMS, of P s-yn-dre, Holywell, died in London on December 15th last, to the deep regret of a large circle of friends and patients. Born on June 29th, 1869, the elder son of the late Dr. James Williams of Holywell, he was educated privately. He studied medicine at University College Hospital, London, and took the diplomas of M.R.C.S. and L.R.C.P. in 1892. He was at different times ambulance surgeon at the Northern Hospital and house-surgeon at the Royal Infirmary, Liverpool, and later joined his father at Holywell, gradually succeeding to the entire practice. In September last, owing to the breakdown in his health, he was compelled to leave home. He was medical officer of health for the Holywell Urban District, district medical officer under the Holywell Rural District Council, public vaccinator, one of the medical officers of the Flintshire Dispensary and Cottage Hospital, certifying factory surgeon for Holywell District, and held other public professional appointments. He was Justice of the Peace for Flintshire and was also a member of the military tribunal for the Holywell area. More than one of the above appointments had been held by his father and grandfather before him, the records of the family practice being traceable back for one hundred years. Dr. Herbert Williams was also in former days an enthusiastic member of the local volunteer company attached to the Royal Welsh Fusiliers, while during the war he was largely instrumental, as captain, in forming and maintaining the present local company of volunteers. He was greatly liked and esteemed throughout the district and by many friends elsewhere. He married in 1910 the daughter of General Inglis of Ryde, who, with two little children, survives him.

DR. JAMES COLLINGS HOYLE died on January 8th at Upham, Hants, aged 50. After studying medicine at St. Bartholomew's Hospital he took the diplomas of M.R.C.S., L.R.C.P. in 1889, and graduated M.B., B.S. of the University of Durham in 1894 and M.D. in 1913. He obtained the D.P.H. in 1892 and held for some years the post of M.O.H. for Gray's Inn. In 1896 he was appointed health medical officer for Rangoon and secretary to the Plague Council for Burma, but after four years was compelled by ill health to resign these posts, to the great regret of all who knew him. During the next year or two he made voyages in search of health, and then settled in practice at Upham in 1892. He was appointed assistant county medical officer of health to the Hampshire County Council in 1911, and later was given charge of two tuberculosis dispensaries. Unfortunately his health again broke down in 1915. For a year or so he acted as medical officer to the Royal National Sanatorium, Bournemouth, but last year he had to give up work entirely. Dr. Hoyle was a man of much zeal and ability, with a very marked capacity for inspiring affection and confidence in all with whom he came in touch.

Medical News.

THE appointment of Frank Cole Madden, M.D.Melb., F.R.C.S.Eng., Professor of Surgery, Egyptian Government School of Medicine, and Senior Surgeon to Kasr-el-Ainy Hospital, Cairo, as Honorary Medical Adviser to His Excellency Sir Reginald Wingate, G.C.B., High Commissioner for Egypt, has been approved by His Majesty's Principal Secretary of State for Foreign Affairs.

THE Research Defence Society and the Association for the Advancement of Medicine by Research have been united into one society, which will retain the name and official address of the Research Defence Society. All such communications as used to be made to the Association for the Advancement of Medicine by Research should now be made to the Research Defence Society, at 21, Ladbroke Square, W.11.

THE first of a course of nine public lectures, on animal life and human progress, at King's College, London, will be given by Professor Dendy on Wednesday next, at 5.30 p.m. The lectures will be continued weekly on Wednesdays at the same hour. The lecture on March 6th, when Sir Patrick Manson will be in the chair, will be given by Dr. R. T. Leiper, Reader in Helminthology at the University of London, on "Some inhabitants of man and their migrations."

MR. EDMUND GOSSE, chairman of the London Library, informs us that that institution has arranged to act as a collecting centre for books, to assist the Red Cross and Order of St. John. Those members of the public who do not use the Post Office scheme are invited to send literature to the Librarian, London Library, St. James's Square, London, S.W., where it will be sorted. Any valuable books will be sold to buy larger numbers, and the whole given to the Red Cross War Library for distribution to the sick and wounded men of the navy and army.

AT the January meeting of the Illuminating Engineering Society Mr. L. Gaster read a paper, in which he discussed the future prospects of illuminating engineering. One of the immediate tasks of the society should be, he said, to obtain statistics showing the prejudicial effects of inadequate and unscientific lighting on the health and eyesight of factory workers. The Health of Munition Workers Committee had produced some evidence that inadequate lighting was prejudicial to health, and might cause headaches and other effects of eyestrain, apart from the fact that it also led to industrial accidents. The society intends to make a detailed survey, in order to place the matter beyond all question.

A CORRESPONDENT who has recently been called up for a fourth medical examination writes to the *Cambridge Daily News* in praise of the new arrangements made by the Ministry of National Service. On the day that he attended the Cambridge office not more than twenty others were called up for examination. The rooms were well warmed and everything possible was done for the comfort of the men. The examination by the four doctors forming the medical board was thorough and individual, and the men were treated with every consideration. After passing through the hands of each member of the board the men were informed by the chairman of the grade in which they placed, and within a very few minutes their cards were handed to them, together with an order for a day's pay to be paid next door. The writer concludes that if everything is done elsewhere as it is done at Cambridge there will be little cause for complaint.

AT a meeting of the Medical Society of Magdeburg, Dr. A. Weinert reported several striking cases of sudden death among soldiers who only a few minutes or hours earlier had been on duty. In several cases of diphtheria in which the diphtherial membrane was spread over the pharynx, larynx, and the whole respiratory tract the patient had remained on duty till about two hours before death. One patient suffering from abscess of the larynx had been off duty only half an hour when he died. One rare cause of sudden death was due to haemorrhage into the suprarenals after a fall. In three cases there were fatal haemorrhages from gastric ulcers, while the patients were also suffering from pneumonia. In a recent paper by Beitzke eleven cases of sudden death among soldiers are recorded in which, at the necropsy, nothing serious enough to be fatal could be found apart from early nephritis; but this was slight.

Letters, Notes, and Answers.

CORRESPONDENTS who wish notice to be taken of their communications should authenticate them with their names—of course not necessarily for publication.

AUTHORS desiring reprints of their articles published in the BRITISH MEDICAL JOURNAL are requested to communicate with the Office, 429, Strand, W.C.2, on receipt of proof.

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, *Medisecra, Westrand, London*; telephone, 2634, Gerrard. The address of the Irish Office of the British Medical Association is 16, South Frederick Street, Dublin.

The address of the Central Medical War Committee for England and Wales is 429, Strand, London, W.C.2; that of the Reference Committee of the Royal Colleges in London is the Examination Hall, 8, Queen Square, Bloomsbury, W.C.1; and that of the Scottish Medical Service Emergency Committee is Royal College of Physicians, Edinburgh.

☞ *Queries, answers, and communications relating to subjects to which special departments of the* BRITISH MEDICAL JOURNAL *are devoted will be found under their respective headings.*

QUERIES.

PAINLESS CHILDBIRTH.

DR. G. BLACKER (45, Wimpole Street, W.) writes: In view of the interest which the subject of "twilight sleep" is exciting at the present time I am anxious to obtain authentic details of any cases in which this method of narcosis has produced dangerous symptoms or a fatal result in either the mother or the child. If any of your readers can furnish me with the particulars of any such cases I shall be greatly obliged.

PAY OF ANAESTHETISTS IN MILITARY HOSPITALS.

ANAESTHETIST in military hospital wishes to know if any other medical officer holding a similar appointment has applied for the special pay of 2s. 6d. a day, and if so whether his application has been successful.

INCOME TAX.

"X" who before the war was in partnership, is now serving abroad and has let his house; he holds certain War Loan stock. The point is whether he is resident in this country.

The residential test would seem to be the same with regard to the exemption from tax on war loan as in the ordinary case of relief from earned income. The special provision contained in Sec. 71 (1) of the Finance (1909–10) Act 1910 provides that a person employed in the service of the Crown abroad shall be entitled to relief "as if he were resident in the United Kingdom," though in computing the total income for the purpose of determining the rate of relief the non-chargeable income would have to be included. We suggest, therefore, that on the facts stated "X" would have reasonable grounds for claiming (1) that his war loan interest is at present exempt from duty and (2) that he is entitled to relief in respect of the rate of tax chargeable on his partnership profits on the special ground that he is employed in the service of the Crown abroad.

ANSWERS.

FINGER CRACKS.

DR. C. J. B. JOHNSON (King's Heath) sends the following suggestion: Heat a piece of shoemaker's wax and fill the crack with it. One application is generally sufficient. The objection to it is the dirty appearance. As a preventive the hands should be thoroughly rubbed with vaseline or oil before washing.

"X" writes: I have had the best results from a solution of celluloid (old photographic film, well cleaned). Dissolve in ether and thin down with amyl acetate. The crack must be perfectly dry, and be kept on the stretch (gaping) till repeated coats of the solution have dried in and filled it up. The essential point to remember is that the object is not to bridge over the crack, and still less to draw its sides together, but to fill it up solidly from the bottom. If well done, it should last, in spite of free use of the finger, washing, etc., till the skin outgrows the crack. Only in extreme cases need a few fibres of cotton-wool be added. This solution adheres better than collodion.

ICHTHYOSIS writes: In my personal experience of this disability, which is considerable, the only treatment I have found really useful is that recommended to me a number of years ago by the late Dr. Allan Jamieson of Edinburgh. A thin wisp of cotton-wool is fixed over the crack (with a good grip of the adjacent nail) by means of "epicolloid," a collodion preparation made by Messrs. Duncan and