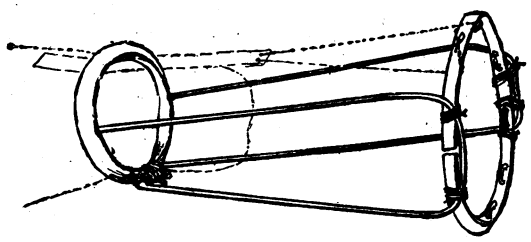
saving device, the division of tissues without regard to adequate flap formation. But thereafter it becomes incumbent upon the surgeon to conserve for the patient every fraction of the stump possible. If the retraction of the soft tissues is permitted to proceed unrestrained until such time as secondary amputation is performed, it will be the general experience that an undue length of femur will require removal before the soft parts are capable of approximation, and that the ultimate shortening of the stump may prove very disappointing.

I am aware that stump extension is at times employed, but such contrivances as are usually made use of cannot, in my opinion, be relied upon to maintain the necessary continuous uniform traction during all movements of the stump and positions of the patient both in bed and during transport.

A splint that I have improvised achieves this, and after its use in numerous cases during the last two years I am able to speak of its utility. Unhappily, many of the cases that arrive in this country have reached a stage in which the tissues are fixed in retraction when counter-extension can obviously be of little use; this note is published in the hope that the splint may receive a trial in France to prevent retraction, and to afford the further advantages to the patient of freeing him from pain and of giving protection to the stump—all important factors during transport.

The splint is improvised from a Thomas splint, as modified by Jones for the arm; its ring will, as a rule, be found to slip comfortably over the thigh. One with a closely fitting ring having been selected, it is forcibly bent at the bars until the end meets the leather-covered ring, to which it is secured by a tape. A blow with a mallet will convert the ring to an oval that will, perhaps, better fit the contour of the thigh. In the rare event of the ring being too small, it may be enlarged by division with a saw close to the outer bar.



Improvised thigh stump extension splint. Note: The aluminium ring is made large when indicated by the condition of the wound, and small when direct extension is required.

A length of about twenty inches of aluminium splinting is then bent in the form of a circle, loops within, and this hoop is then inserted and secured by tape or strapping between the ends of the bent bars of the Thomas splint, which are forced apart, if necessary, to receive it. The splint is now complete, and takes but a few minutes in the making.

Extension strapping is next applied to the whole length of the stump at the points of the circumference selected as best suited for effective flap extension. The projecting ends of the strips should be folded so that their adhesive surfaces are effaced, and in each two openings are snipped for the passage of tape that is so passed as, when extension is made, to appose the lateral edges of the plaster to the skin. The coaptation of the plaster strips to the surface is further secured by a circular band of the same material round them all near the end of the stump. Efficient substitutes for adhesive strapping, and in some ways better, are strips of bandage or gauze affixed in like maner with glue.

The splint is now applied, the padded ring being carefully insinuated upwards until it gets a firm bearing against the tuberosity of the ischium. Being close fitting it gives additional security against slipping of the extension strips.

Extension is now made by drawing upon the tapes or strips and securing them by adequate tension in the direction of their application to their corresponding segment of the aluminium ring by slip-knots, daily attention to which will ensure that a uniform tension is maintained conforming with the give of the soft parts.

The splint is light, and forms a frame that supports and moves with all movements of the stump, the flaps of which are held in fixed extension, while the splint is self-secured by means of its extension bands. Extension is maintained whatever the position of the stump and whatever its movement, so that the position of the patient can be varied and attendance on him rendered easy. After the application of the splint the patient is freed from pain, and no cradle is necessary, as the splint affords the necessary protection. The open aluminium ring allows access for swabbing and dressing, and from the side a kidney-shaped dish can be introduced beneath the wound.

The dressings being maintained in position by the framework of the splint, no bandage is required, so that access to the wound is ready and provides for prompt attention in case of haemorrhage.

I should like particularly to recommend the use of this splint during transport. The material is available and it requires only a few minutes to be made. In October, 1915, Sir G. H. Makins showed an adaptation of a Thomas knee splint, but not of the same character as mine.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

LONG LIFE AFTER EXCISION OF RECTAL CANCER.

IT is well known that freedom from recurrence after complete removal of cancer of the intestine is more likely than in many other situations. As it is not always easy to obtain the history of a case after many years, I am much indebted to Sir William Whitla, of Belfast, for giving me the completed record of a case thirty-one years after operation. Such a case is of much interest, and affords encouragement. In 1887 I operated in Belfast upon one of Sir William's patients, assisted by Mr. (now Sir Anthony) Bowlby and Mr. Sinclair of the Belfast Royal Hospital.

The patient was a lady 53 years of age, who had had symptoms for six months. Examination under an anaesthetic showed that the disease commenced three inches above the anus, and extended upwards about four inches. It completely surrounded the bowel, producing considerable stricture. The posterior wall was more deeply invaded than the anterior. The operation was difficult and prolonged, but eventually, after freely opening the peritoneum, a complete segment of the bowel five inches in length was removed, including half an inch of sound margin both above and below the growth. Microscopic examination showed a typical specimen of adenoid cancer. The patient, under the care of Sir William Whitla and Mr. Sinclair, made a good recovery.

Five years later, owing to some contraction, an inguinal colotomy was performed (not under my advice). I saw the patient thirteen years after the operation. She was in excellent health, and there was no sign of recurrence. The colotomy opening gave hardly any trouble.

Sir William Whitla has most kindly sent me, under date February, 1918, a letter as to the sequence of the case: "I enclose a card informing you of the death of your old cancer case operated on in 1887. She has just died at the age of 84. Surely this is a record."

W. HARRISON CRIPPS,
Consulting Surgeon to St. Bartholomew's Hospital.

THE GUILLOTINE AMPUTATION.

THE number of cases in which a guillotine amputation has been performed at casualty clearing stations and base hospitals in France induces me to ask if some other method of amputating could not with safety be practised. Unfortunately I have not had an opportunity of seeing cases as they present themselves at a casualty clearing station, but I think it is equally unfortunate that so few surgeons working at the front have not had an opportunity of seeing the after-results of the guillotine method.

It may be that the fear of gas gangrene is the important factor which has caused this plan to be adopted so generally. A guillotine amputation invariably necessitates reamputation, but, apart from this, the great disadvantage is that by the time the patient arrives in England the skin has retracted so much that a large granulating and suppurating stump is exposed. The

dressings are often extremely painful, and the subsequent loss of bone, even after prolonged extension to draw the skin down, is sometimes very great.

May I suggest that in a fair proportion of cases flaps might be made and brought together by rubber button sutures, as advocated for reamputation by Major W. A. Chapple in the BRITISH MEDICAL JOURNAL of August 25th, 1917, p. 242? Ample provision for drainage is, of course, essential. I have adopted this plan in a number of re-amputations with marked success, even in the presence of active suppuration.

I have been working at this hospital since August, 1914, and can recall distinctly the very unsatisfactory results obtained during the early part of the war, when amputations in France were performed in the orthodox way. At that time the flaps were made too close to the injured tissues, were stitched too closely, and adequate drainage not provided for. Now the pendulum has swung so far in the opposite direction that a few weeks after the operation, owing to skin retraction, the appearance of the stump would almost suggest that the patient had been amputated from the limb and not the limb from the patient.

If surgeons in France decide that after all it must be a guillotine amputation, I hope they will so modify it as to leave much more skin, and so dispense with many subsequent troubles, and save the ultimate length of the patient's limb.

I trust these remarks will be read in the spirit in which they are written, for I feel very proud of the excellent work being done by British surgeons at the casualty clearing stations in France, more especially in regard to abdominal injuries and wounds of joints. Why not bring amputations up to the same high level? The fact that we surgeons are all working for the same end—to learn what is true in order to do what is right—will, I trust, be a sufficient excuse for me venturing to criticize the work of others in a particular branch of surgery.

R. W. MURRAY, F.R.C.S.,
Major R.A.M.C.(T.).
1st Western General Hospital, Fazakerley, Liverpool.

SPONTANEOUS HAEMORRHAGE INTO THE PERITONEAL CAVITY IN ARTERIO-SCLEROSIS.

THE occurrence of spontaneous haemorrhage in cases of arterio-sclerosis with high blood tension is a matter of everyday experience, especially from the cerebral arteries. That such haemorrhages are not entirely confined to these arteries is also well recognized, as cases of severe epistaxis, metrorrhagia, haematemesis, and haematuria arise in the course of arterio-sclerosis. In the description of this disease in textbooks I have not found any mention of haemorrhages into the peritoneal cavity, and on this account report the following case.

Mr. T. M., aged 48, consulted me in March, 1912, complaining of transient loss of power over the lower limbs, headache, dizziness, and depression. He had hard and tortuous arteries, accentuation of second aortic sound of heart, and a blood pressure of 160 to 170 mm. In 1915 his symptoms had grown worse, and the blood pressure had increased to 180 to 190 mm. In July, 1915, he had left hemiplegia, from which he recovered. He also suffered from nasal polypi, and in September, as these were causing troublesome nasal obstruction, I removed them by snare. This operation was followed by severe haemorrhage, which was very difficult to control. In 1918 his condition was such that he found relief from his symptoms only by remaining in bed. On February 5th he remained in bed until the afternoon. He then got up, and, when taking some tea, was seized by a violent pain in the epigastrium. I saw him about an hour afterwards. He was then crying out with pain. His temperature was subnormal, and pulse 80. The abdomen was distended; the abdominal wall was rigid and board-like. There was dullness in both flanks, but no absence of liver dullness. I advised immediate operation.

Operation.—On opening the abdomen the upper part of the cavity was found full of blood. After swabbing this out I found a series of haemorrhagic patches scattered over the mesocolon, but failed to find any actual bleeding point. As his condition was very grave, and the haemorrhage had ceased, I closed the abdomen. Before doing so I examined the liver and the region of the pancreas, but could find nothing abnormal. There was no fat necrosis. He died six hours afterwards.

The interesting points of the case are:

1. The spontaneous nature of the haemorrhage without any history of trauma.

2. The close simulation of the symptoms to those following a ruptured viscus. The clinical picture presented at the commencement of the haemorrhage was typical of perforated gastric ulcer.

J. W. HILLIARD, M.A., M.D.,
Honorary Surgeon, Victoria Hospital, Blackpool.

RESUSCITATION OF WOUNDED.

A GOOD deal is now being done to resuscitate wounded men suffering from shock of wounds and exposure, with a result that is at once successful to the patient and encouraging to his medical officer. The transfusion of gum solution or blood has been so markedly successful in bringing round in a few minutes many wounded men who would otherwise have died, that it suggests the possibility of going a little further. My object is in no way to challenge the methods of resuscitation in use, methods which stand on the firm rock of results, but to deal rather with the soldier at a much earlier period, so as to have certain data in hand which might serve as a guide to the intelligent treatment of cases after the first shock of battle has been tided over. I refer to the taking of the specific gravity and viscosity of the blood of every recruit at some early stage—for instance, when the man is at the height of his training, in the best possible physical condition, and every function well and equally balanced. A true index might thus be found which, if put on his card, might help to regulate intelligent direction of treatment later on if necessary.

Present methods of treatment after operation appear to me to savour too much of groping in the dark. A bridle rein is required to guide us in our movements to the goal we would attain, and this communication is a plea that perhaps Nature has the guide ready to our hand. No two individuals have quite the same diathesis; every one has his own standard. Where in one the specific gravity may be 1 or zero as his normal necessary to perfect health, in another it may be *plus* or *minus* 1 as the case may be, and to raise the *minus* too much or to raise the *plus* insufficiently might just make all the difference.

While in charge of a V.A.D. hospital in England I, in a necessarily incomplete way, put this process into practice early last year, and took the viscosity and specific gravity of the blood of many wounded soldiers. Making the normal at zero, I found very few who came up to this standard or who agreed with each other. At the time I felt very much handicapped in not knowing the specific gravity and viscosity index of the individual in normal health, but even so I met with sufficient success to warrant considering the thing seriously. The taking of the specific gravity of every soldier would entail very little time, and could be done easily, quickly, and fairly accurately with mixtures of known specific gravity (ether, glycerin, etc.) in three or four bottles, and would require no more blood and much less time than is required in an ordinary blood count. Of course much more elaborate processes could be employed, and might be so later on in civil hospitals, but the above, I am sure, would be sufficiently accurate to meet the need, and would, I am convinced, be of immense assistance to the medical officer. By gradually raising the patient to his normal index and maintaining it at that by the use of gum solutions, or saline or other methods, his diathesis could more speedily be brought to an efficient degree, increasing his resistance to septic processes, and thus restoring him to health, and shortening the period of convalescence to that which now obtains. It is in view of the probably large influx into the army in the near future of men different and indifferent alike in physical qualities and standards of health that I with great diffidence send this communication.

ROBERT B. JOHNSTON, F.R.C.S., M.R.C.P.E.,
Lieutenant R.A.M.C.

BARCOO ROT (VELDT SORE).

IN the JOURNAL of June 9th, 1917, p. 761, Lieut.-Colonel C. J. Martin has made a very interesting addition to the pathology of barcoo rot, or veldt sore.

To those of us who have lived in tropical Africa any length of time the condition is well known, and is commonly referred to by the layman as "fever sore." Martin lays stress on the infection of the hair follicles being primary; with this I am inclined not completely to agree. I believe in many cases the initial lesion is a trauma through which the infection takes place, otherwise how is the distribution—backs of hands, extensor surfaces of

forearms and shins, that is to say those parts exposed to trauma—to be explained? Why are not other parts of the body, though admittedly generally less hairy, not affected? With an affected area the size of a threepenny piece on the back of the hand, naturally one or more hairs will be found passing through the lesion, and one would expect to find the follicles infected, but I am not convinced that this is primary. On the other hand, I do believe that hair follicles in the neighbourhood are secondarily infected by organism-containing discharges from the primary sore, just as happens in any pyogenic skin infection with the production of secondary lesions.

With Harman's view of the etiology, quoted by Martin, most of us will doubtless agree—namely, that the skin cocci are able to infect the epidermal structures of a man whose defences are weakened. The loss of resistance may be from many causes. The most marked case I have seen was in a European with symptoms of scurvy, but malaria, as is indicated by the local name, is often the predisposing cause. Want of cleanliness and attention I believe assist in the spread of the lesions, but not necessarily in the production of the initial lesion.

One other point. I am not convinced that similar infections do not take place in natives; the reason that they are not observed being that every skin lesion becomes immediately secondarily infected with pyogenic cocci, and its character thus changed.

With regard to treatment, I have had uniform success with a 20 grains to the ounce salicylic acid ointment after preliminary cleaning up of the ulcer and snipping away any overlying epidermis. Tropical practitioners will be, however, greatly indebted to Colonel Martin for pointing out the part the hairs play in delaying the healing, and in being responsible for the spread of the ulcer at its margins.

H. S. STANNUS, M.D.,
S.M.O., Occupied Territory, G.E.A.

Reports of Societies.

TREATMENT OF TUBERCULOUS MESENTERIC GLANDS.

AT a meeting of the Medical Society of London on February 11th, the President, Sir STCLAIR THOMSON, being in the chair, Mr. HERBERT CARSON, in a paper on the clinical aspects of tuberculous mesenteric glands, expressed the opinion that the resistance of the glands was lowered by septic invasion from the intestinal tract and subsequently infected with tuberculosis from the same source, the tubercle bacilli reaching the intestine in milk. He analysed a series of 50 cases submitted to operation, describing three stages—that is, simple enlargement, caseation, and calcification; 37 of the patients were below and 13 above 15 years; many patients had been ill for two or three years. In giving a description of a typical case he referred particularly to pain, which he considered diagnostic. It was a true colic, and due to tonic contraction of the circular muscular coat of the bowel. The condition had to be distinguished from chronic appendicitis, ureteric stone, digestive disorders, intestinal parasites, and lead poisoning. Complications were almost all of the type of intestinal obstruction. There were three cases of intussusception in the series, which Mr. Carson considered to be due directly to spasm of the affected segment of intestine. With regard to treatment, the necessity of correcting diseases of the nose, pharynx and mouth was emphasized and laparotomy advised even in typical apparently uncomplicated cases. Mr. Carson advocated removal of the glands rather than curetting in the uncomplicated cases. Where there was obstruction he advised the removal of the glands and the freeing of adhesions or enterectomy rather than short-circuiting or the formation of an artificial anus. The paper contained an analysis of the after-results in the 47 cases of recovery.

Dr. LEONARD GUTHRIE said that in his experience calcified tuberculous mesenteric glands were usually found only after death. They were very difficult or impossible to palpate. He thought colic was not sufficient for diagnosis. He was not accustomed to ask for operation for free fluid. Intussusception, of course, and obstruction from whatever cause, must have surgical aid. In his own hospital the recoveries with medical treatment amounted to 80 per cent., and with surgical treatment to 50 per cent., the latter including surgical complications.

Mr. V. WARREN LOW thought that colic was not evidence of uncomplicated tuberculous mesenteric glands, but was definite evidence of obstruction of the intestine, due probably to a kink or adhesion. When he operated he usually left the glands alone, and prescribed rest, small doses of tuberculin, and open air. A large proportion of cases got well. He had always found the colic associated with a rise of temperature which was out of proportion to the clinical symptoms. He had not regarded tuberculous mesenteric glands as a clinical entity.

Dr. WALTER CARR thought it impossible for tuberculosis of the glands to go on to calcification without fever. Were tuberculous mesenteric glands found in every case in which the typical symptoms occurred? Calcareous glands were often found in the abdomen *post mortem*; they did not usually give rise to tuberculous peritonitis, this being caused by (1) blood infection and (2) local extension of infection from the intestine. Tuberculous mesenteric glands might give rise to miliary tuberculosis. In London the bronchial glands were more often the source of infection, whereas in Scotland the infection appeared, as a rule, to come from mesenteric glands.

Mr. H. J. GAUVAIN agreed that tuberculous mesenteric glands existed without tuberculosis elsewhere. Of 2,000 cases of the bones and joints the mesenteric glands were affected in some. He had never come across the colic described by Mr. Carson as typical of these cases. He did not operate to remove the glands. The treatment he used was open air, and, when the glands were getting smaller, he endeavoured to assist calcification by administering calcium salts.

Dr. EDMUND CAUTLEY thought that the symptoms described were not evidence of tuberculous mesenteric glands. He considered that many of Mr. Carson's cases were not instances of purely tuberculous mesenteric glands, for there were complications which showed extension to the peritoneum. Operation was not profitable unless there was a complication indicating the necessity for it.

Mr. CARSON, in reply, said that he regarded colic as a constant symptom, and without it a diagnosis of tuberculous mesenteric glands should not be made. The children he had described were all on the down grade, getting thinner and more ill. In his experience pain was not usually associated with the complications.

SYPHILIS AND STILLBIRTHS.

AT a pathological meeting of the Liverpool Medical Institution on February 14th, Mr. W. THELWALL THOMAS, President, in the chair, Professor J. M. BEATTIE read a note on the examination of 409 stillbirths for evidence of syphilis. Spirochaetes were found in the organs (liver, spleen) in 49. The blood of 35 fetuses showed a positive reaction in 26 and a negative in 9. Related to these 9, the mothers showed the following results: 4 were positive, 4 were indecisive, and one was negative. Absence of spirochaetes was noted in one fetus, in which, however (and in the mother), the blood test was positive. The negative result of the blood test in 9 fetuses was ascribed by Professor Beattie to probable bacterial infection of a saprophytic nature, interfering with haemolysis. His conclusion was that the prevalence of syphilis in regard to stillbirths was 15 per cent., and his results corroborated those of other observers. He considered it most desirable, in the absence of other obvious causes of stillbirths, that the blood should be examined with the object of ascertaining the presence or absence of syphilis. Dr. BRIGGS, professor of midwifery and gynaecology, agreed with the findings of Professor Beattie and said that the clinical evidence supported them.

VOGEL of Breslau has found that though the total incidence of venereal disease in the German army was comparatively low (about 0.3 per cent.), syphilis, as compared with gonorrhoea, had become more common. The incidence ratio of syphilis to gonorrhoea, which was as 1 to 3 or 4, had risen to 1 to 2. Another disquieting fact was the high proportion of married men—a third of the total—among infected soldiers.

devoted to his garden, and he delighted in the cultivation of roses, whilst he derived great pleasure from the meetings of the Royal Horticultural Society. Seward's mind was not that of a controversialist, indeed he rather disliked debated questions, but he always expressed his opinions—which were well considered—both critically and fearlessly. His great charm was his complete detachment from bias—he had cultivated the bias of anti-bias more than any other man of the writer's acquaintance, and he was a most genial, well-informed and cheerful personality. He always maintained the complete confidence and friendship of his committee as well as of their officials.

Dr. George Stokes Hatton, who died on January 15th at Wimborne, Dorset, was for many years a well-known practitioner in North Staffordshire, until failing health caused his retirement to the South of England. After studying medicine at St. Thomas's Hospital and at Newcastle-on-Tyne, he obtained the diplomas of L.S.A. in 1879 and M.R.C.S. in 1880, and graduated M.B., M.S.Durh., proceeding M.D. in 1882. In 1894 he became F.R.C.S. Edin. Dr. Hatton held resident posts at the North Staffordshire Infirmary, and, on his leaving there, joined Dr. Orton in practice at Newcastle-under-Lyme. He was soon appointed to the assistant staff as surgeon to the infirmary, and in turn became full surgeon, and then was appointed consulting surgeon on leaving the district. Dr. Hatton was a successful practitioner and possessed surgical skill and dexterity to a marked degree. His death will be regretted by a large circle of patients and friends in North Staffordshire.

The death occurred on January 28th of Dr. George Henry Eccles, aged 76, who had practised in Plymouth for over fifty-five years. After studying at St. Bartholomew's Hospital, Dr. Eccles obtained the M.R.C.S. diploma in 1862, the L.R.C.P.Edin. and the L.S.A. in 1865. Having held the post of house-surgeon at St. Bartholomew's Hospital, he set up in practice at Plymouth, where he held a considerable number of appointments as surgeon to charitable institutions. Dr. Eccles was a man of remarkably strong character and sacrificed much for his religious convictions. He leaves three sons in the medical profession: Dr. G. Tolcher Eccles, of Hove; Captain H. Nisbet Eccles, R.A.M.C.; and Captain G. Dunluce Eccles, R.A.M.C.

Dr. William Cardiff Hossack, port health officer of Calcutta, died in Calcutta on January 5th. He was the eldest son of Mrs. Garden Milne Hossack, of St. Catherine's, Banff, and was educated at the University of Aberdeen, where he graduated M.B. and C.M., with honours, in 1894, and M.D. in 1898. For the last twenty years he had served in Bengal, where he had held the posts of special plague officer, health officer to the Corporation of Calcutta, district medical officer, and health officer of the port of Calcutta. He was the author of a monograph on the rats of Calcutta.

Brigade Surgeon John Law, Madras Medical Service (retired), died at Guildford on February 6th, aged 83. He was the second son of the late Thomas Hooper Law, of Barnstaple, and entered the I.M.S. as assistant surgeon on May 28th, 1858, becoming surgeon on May 28th, 1870, and surgeon-major on July 1st, 1873, and retiring, with a step of honorary rank, on February 1st, 1882. During the later part of his career he held the important appointment of residency surgeon, Haidarabad.

Brigade Surgeon William James Wilson, R.A.M.C.(ret.), died at Southsea on February 8th, aged 80. He was educated at Queen's College, Belfast, where he graduated M.D. in 1860, and took the diploma of M.R.C.S. in the same year; he entered the army as assistant surgeon on April 1st, 1861, became surgeon on March 1st, 1873, surgeon major on April 1st, 1873, and retired as brigade surgeon on May 2nd, 1888. In the old regimental days he served in the 28th Foot, now the Gloucestershire Regiment, and later he commanded the station hospitals at Portsmouth in 1885–86, and at Mhow in 1887. He served in the Afghan war, in 1880–81, in the Southern Afghanistan Field Force; and in the Soudan in 1885, commanding No. 1 Bearer Company in the Suakin Field Force and receiving the medal with a clasp and the Khedive's bronze star.

Deputy Inspector-General James Crawford Dow, R.N. (ret.), died recently at Bath of congestion of the lungs, the result of an accident, when he fell and broke his leg in a rough sea, returning from Australia last May. He was educated at Glasgow University, where he graduated M.B. and C.M. in 1870, and entered the navy soon after, attaining the rank of fleet surgeon on June 4th, 1893, and retiring, with a step of honorary rank, on September 21st, 1904.

Universities and Colleges.

UNIVERSITY OF OXFORD.

At a congregation held on February 16th the following medical degrees were conferred:

D.M.—W. R. Reynell (*in absentiâ*), G. T. Hebert.

UNIVERSITY OF BRISTOL.

The following candidates have been approved at the examination indication:

Final M.B., Ch.B.—*Part I, including Forensic Medicine and Toxicology:* Elizabeth Casson, A. D. Symons. *Part I only:* B. A. Astley-Weston, A. G. Bodman, R. F. White.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

An ordinary Council was held on February 14th, when Colonel Charters Symonds, Vice-President, was in the chair.

Diplomas of membership were granted to eighty candidates found qualified at the recent examinations. Diplomas in Public Health were granted jointly with the Royal College of Physicians to two candidates found qualified.

The Begley Studentship was opened to women as well as to men.

A resolution having been passed by the College of Physicians for the omission of biology from the first professional examination, the subject was referred by the Council to a special committee for report.

The Secretary reported that, in pursuance of the provisions of the new by-laws, the date of the next Council election would be announced by advertisement and by circular on March 8th, and that March 18th would be the last day for the nomination of candidates.

COLLEGE OF MEDICINE, NEWCASTLE-ON-TYNE.

The council of the college has elected Dr. David Drummond to be president of the University of Durham College of Medicine, Newcastle-on-Tyne, in succession to the late Sir George Philipson, and the chancellor has appointed him pro-vice-chancellor of the university. Dr. Drummond graduated M.D.Dubl. in 1876, became physician to the Children's Hospital shortly afterwards, and in 1878 became physician and pathologist to the Royal Victoria Infirmary, and is now consulting physician. He is also joint professor of the principles and practice of medicine in the University of Durham. At the annual court of governors of the college he was elected vice-chairman. At the same meeting it was announced that the number of students at present in attendance was 168, or 26 more than a year ago. The number of women students has increased by 50 per cent., and they now form 25 per cent. of the total. Dr. F. H. A. Clayton has been appointed lecturer in bacteriology, and Dr. Helen G. Clark part-time assistant. The routine work of the department has been increased, as it has been arranged to conduct for a number of urban and local authorities the bacteriological investigations required by the Local Government Board under the venereal disease regulations. Additional accommodation has been provided at the cost of about £600.

CONJOINT BOARD IN ENGLAND.

The diplomas of L.R.C.P. and M.R.C.S. have been conferred upon the following:

G. V. W. Anderson, Mary Andrews, H. C. Apperly, C. W. W. Armstrong, K. E. Attenborough, Loveday S. Banes, M. Baranov, E. R. Batho, C. C. Beney, P. F. Bishop, J. C. Blake, J. S. Boruchowitz, R. B. Britton, H. S. Bryan, F. Caldecott, G. T. Calthrop, J. D'A. Champney, H. A. Chodak, W. B. Christopherson, A. E. Clark-Kennedy, C. B. Cohen, W. Collins, R. N. Craig, T. L. Crawhall, H. T. Cubbon, Jatindra Kumar Datta, C. Depla, A. R. Doyle, F. B. Dutton, F. N. V. Dyer, Abdel Aziz Hassan El-Zenieny, W. Feldman, A. F. M. Fuoss, G. H. Gidlow-Jackson, Eryl Glynne, W. N. Goldschmidt, W. H. Grace, R. B. Green, W. S. Gross, W. M. Heald, J. M. Higginton, E. A. Holmes, J. Hope, H. B. Jackson, W. A. Jolliffe, D. M. Jones, J. W. Jones, M. E. Jones, T. P. Kilner, D. M. Lâlâ, F. W. M. Lamb, J. G. Lawn, Marguerite F. J. Lowenfeld, G. E. MacAlevey, H. M. Menage, Daisy K. F. Michael, H. Millett, L. M. Moody, D. M. Muir, Annie S. Mules, P. M. Neighbour, Vijaya Shankar Rao Pandit, E. J. Papenfus, A. L. S. Payne, T. M. Payne, A. V. Pegge, A. Peine, Sybil M. G. Pratt, Joyce B. Reed, H. T. Rymer, H. M. Savery, C. K. Scales, G. A. S. Shacklock, B. B. Sharp, A. G. Shurlock, G. H. Sims, A. R. Tothill, J. T. Wall, A. S. Westmorland, E. Wolff, F. G. Wood.

Medical News.

THE fourth meeting of the Inter-Allied Surgical Conference will be held early next month. The last conference took place in Paris in November last, and an account of its conclusions was published in the JOURNAL of January 5th, p. 28.

THE Home Secretary announced in the House of Commons on February 20th that summer time for 1918 would commence at midnight, Sunday, March 24th, and terminate at midnight, Sunday, September 29th.

THE Parliamentary Secretary to the Ministry of Food (Mr. Clynes) has stated that the number of standard barrels of beer brewed for consumption in the United Kingdom during 1917 was 16,133,800, and that the quantity of materials used for the first nine months of the year was 28,620,800 bushels of malt, 61,200 cwt. of rice, 6,200 cwt. of maize, and 1,613,700 cwt. of sugar or its equivalent. He stated also that the quantity of spirits retained for consumption as beverages in the United Kingdom in the year ending December 31st, 1917, was 18,549,406 gallons.

THE delivery of the Hunterian lecture on the pathological aspects of certain war injuries of the eye, announced to be given at the Royal College of Surgeons of England by Colonel W. T. Lister, on February 25th, has been unavoidably postponed until May 8th.

DR. ROBERT A. LYSTER, lecturer in public health and forensic medicine at St. Bartholomew's Hospital, and county medical officer for Hampshire, has succeeded Sir Shirley Murphy as editor of *Public Health*, the official journal of the Society of Medical Officers of Health.

AT a meeting of the Shakespeare Association at King's College, Strand, on Friday next, at 5 p.m., Dr. Ralph W. Leftwich will read a paper on Doctor John Hall, Shakespeare's son-in-law.

THE Fire Brigade Committee has brought to the notice of the London County Council the work of Mr. Somerville Hastings, surgeon-in-charge of the ear and throat department of the Middlesex Hospital, in connexion with a fire caused by bombs from hostile aircraft. In rendering medical attention to a man who was pinned under some débris, Mr. Hastings shared the risks of members of the Fire Brigade, regardless of the fact that he had no helmet or other protection, and that débris were falling.

AT the annual meeting of St. Mark's Hospital for Cancer, Fistula, and other Diseases of the Rectum, City Road, London, when the Lord Mayor was in the chair, it was stated that soldiers suffering from rectal diseases and injuries were being treated, and that so far all had been discharged cured, although it had been necessary to keep some in the wards for as long as four months. An opportunity has occurred to purchase a vacant site adjoining the hospital and an appeal for £4,000 to complete the amount needed is being made.

STATISTICS for the year 1916 of the twenty-six German towns with a population of over 200,000 each show a decline of 38.3 per cent. in the birth-rate as compared with 1914. The figures for August and September, 1916, were, however, better than for the preceding July, a result, it is supposed, of the facilities given to soldiers for Christmas leave.

THE Reichstag debate, in which the patrons of salvarsan were accused of suppressing salvarsan fatalities, and in which the medical journals were said to be accomplices to the unscrupulous exploitation of this drug, has had a sequel. In an order from the Prussian Minister of the Interior, dermatologists, specialists in venereal diseases, a the heads of medical institutions are required to give a return showing the number of patients treated and of injections given, and the nature and number of the ill effects observed. Information is asked as to the benefits resulting from the treatment of syphilis with salvarsan and its derivatives.

THE first general meeting, since the war, of the German Medical Association was held in Leipzig on September 22nd and 23rd, 1917. It was stated that about 24,000 German doctors were engaged on war work, and that about 1,000 had fallen in the field. The attacks of the insurance societies on the medical profession, and the prospect of loss of independence by the adoption of a state medical service were discussed. Bitter conflicts with the insurance societies after the war were foreshadowed. With regard to the establishment of dispensaries for the treatment of venereal disease it was agreed that the medical profession should be adequately represented. Unanimity was also shown in a resolution calling for higher remuneration in every branch of the medical profession in view of the depreciation of the currency.

Letters, Notes, and Answers.

ORIGINAL ARTICLES and LETTERS *forwarded for publication are understood to be offered to the* BRITISH MEDICAL JOURNAL *alone unless the contrary be stated.*

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.

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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 AND ANSWERS.

VOLUNTEER TRAINING CORPS.

M.O. asks for information as to the conditions of service applicable to the medical officer appointed to a Volunteer battalion. "Everyone," he writes, "seems to agree that the time is not far distant when the Volunteer Force will be mobilized. A medical man is gazetted as 'temporary lieutenant and medical officer.' In his case does length of service qualifying for promotion count from the date of the *Gazette* notice or from the date of mobilization, and is his pay that of the temporary officer or of the Territorial officer?" Authentic information on these points would, he thinks, be of benefit to those who have joined or are about to join the V.T.C.

"LAMBETH DEGREES."

S. N. asks what powers or privileges the Archbishop of Canterbury has with reference to conferring the degree of M.D.

*** The power of bishops to grant licences to practise medicine doubtless originated in the claim of the church, whose authority was embodied in the Pope, to control all matters relating to education. Some historical notes were published in the BRITISH MEDICAL JOURNAL of December 28th, 1912, p. 1766, where an Act of Henry VIII (1511) defining the mode of exercise of the right was quoted. Some twenty years later an Act was passed empowering the Archbishop of Canterbury to grant degrees in divinity, medicine, and arts. These degrees have commonly been known as "Lambeth degrees." Dr. S. D. Clippingdale informs us that the holders wore the same robes as those holding the corresponding degree of the university to which the Archbishop himself belonged. The Archbishop of Canterbury voluntarily surrendered his right to confer the M.D. when the Medical Act of 1858 was passed. In the BRITISH MEDICAL JOURNAL of December 21st, 1912, p. 1718, a licence granted by the Bishop of Norwich in 1561 was quoted in full.

LETTERS, NOTES, ETC.

NEW DIET RESTRICTIONS.

R. J. R. writes to express the opinion that while most people approve of the rationing principle in general they expect an exemption for any particular case in which they are interested, and believe that all that will be necessary is to apply to their doctor for a certificate. "Unless," he continues, "the regulations for special certificates are made very strict and very definite, there is a risk of very extensive evasion of the orders of the Food Controller. The case of milk is, perhaps, the most important, the case of cream and butter being considered with it; but a particularly flagrant example is that of beef-tea. Taking into account the very small food value of this pleasant extract and the proportionately large amount of the best meat sacrificed to make it, it is to be hoped that in this instance the Food Controller's ruling will be almost prohibitive of certificates."

THE ADVANTAGES OF TEPID BATHS.

DR. GERALD W. MAW (Bedford) writes to recommend the use of tepid baths both as a war economy and because he believes that many people injure their physical condition by frequent and prolonged bathing in hot water. He quotes the case of