and hepatic ducts showed acute inflammation; the gall bladder was distended with semi-purulent greenish bile containing paratyphoid B organisms. I am indebted to Captain C. H. Corbett, R.A.M.C., whose case it was, for the above notes.

This was undoubtedly a case of ascending catarrhal jaundice, spreading upwards from the duodenum, common bile duct, hepatic ducts, to the smaller bile ducts, causing obstructive cholangitis from a paratyphoid B infection.

When we consider the great effect climatic conditions and environment have on disease, and the fact that a disease may change greatly in type after a period of years, as, for example, scarlet fever, it is not surprising that in countries like Mesopotamia and the Dardanelles the incidence rate of jaundice should be decidedly higher than in England, France, or America. Exactly the same kind of variation in jaundice incidence is well shown in influenza and pneumonia epidemics.

Dysentery.

Jaundice is not a symptom of either form of dysentery, and does not usually occur in the early stages of the disease. In severe cases with extensive ulceration jaundice does sometimes occur. This is probably due to secondary infection facilitated by the damaged bowel. It will be shown later that there is evidence of a causal connexion between dysentery and epidemic catarrhal jaundice, the former having some predisposing influence on the latter.

Typhus Fever.

The occurrence of jaundice in typhus fever is very uncommon. I saw it in two cases in Mesopotamia in which relapsing fever infection could be excluded. Jaundice is not mentioned by Osler or Castellani amongst the symptoms or complications of typhus. If jaundice occurs in a case of typhus it is generally an indication of an additional infection—malaria or relapsing fever—which blood examination will elucidate.

Pneumonia.

Jaundice not infrequently occurs in pneumonia; Osler points out that there is a curious irregularity in its occurrence in different outbreaks.[20] Blankenhorn found jaundice in 12 out of 40 cases examined in America, and all had urobilin in the urine. The incidence of jaundice in pneumonia appears to be much higher in America than in England. It is due probably to intrahepatic catarrh of the fine bile ducts and its presence does not necessarily increase the gravity of the prognosis.

Influenza.

Jaundice has been recognized for some time as an occasional symptom of influenza, especially of gastro-intestinal type. Osler states that in some epidemics it is common. In the cases seen in Mesopotamia, uncomplicated by malaria, jaundice was extremely rare. In the influenza epidemic at Bramshott, September and October, 1918, according to Lieut.-Colonel Cooper Cole, C.A.M.C.,[21] jaundice of considerable degree was usually of bad omen, and in fatal cases of this kind "fairly marked hepatic degeneration and occasionally perihepatitis" were found *post mortem*. Major-General Sir Wilmot Herringham, in opening the discussion on influenza[22] on April 10th last, at the Special Clinical and Scientific Meeting of the British Medical Association in London, referred to the recent epidemics which had attacked our army in France. He pointed out that in the epidemic of July, 1918, pulmonary symptoms first began to appear, and this was followed by a most severe outbreak in September, with a mortality of 5 per cent., which subsided in January, 1919. A third epidemic of lesser severity and incidence commenced in March, and in it jaundice became an associated symptom.

Syphilis.

The occurrence of jaundice in syphilis is so well known as to need only brief mention. In the acute secondary stage jaundice is not uncommon, and is probably due to intrahepatic catarrh of the finer bile ducts and increased destruction of red blood cells. In congenital and tertiary syphilis the hepatic fibrosis, whether unilobular, multilobular, or in gross patches forming gummata or scars, is commonly associated with jaundice.

Yellow Fever.

In this disease the most profound degenerative changes attended by fatty deposition are produced with great rapidity in the liver cells, and there is also a marked increase in the destruction of red blood cells. Definite jaundice commences as early as the second day, thus, according to Osler,[23] "the early manifestation of jaundice is undoubtedly the most characteristic feature of the facies of yellow fever."

As in phosphorus poisoning, delayed chloroform poisoning, and arsenobenzol poisoning, so with yellow fever, there is a short quiescent period of two or three days following the symptoms of the initial stage which last three or four days. In severe cases the quiescent stage is followed by increased depth of jaundice and the gravest symptoms—black vomit, haemorrhages from the gums or other mucous membranes, petechiae of the skin, albuminuria, delirium, subsultus tendinum, possibly convulsions, Cheyne-Stokes breathing, coma, and death.

These symptoms of the third stage of yellow fever are familiar, for they are those of "icterus gravis," which is the usual *finis omnium* of all the fatal forms of toxic jaundice.

Pyaemia and Septicaemia.

In conditions of septico-pyaemia jaundice not infrequently occurs, an important causal factor being the great haemolysis caused by the circulating toxins.

In septico-pyaemia affecting the portal distribution suppurative pylephlebitis and multiple liver abscesses are likely to occur and will be associated with definite jaundice, rigors, intermittent high pyrexia, enlarged very tender liver, and other signs of septic poisoning.

References.

[18] Weil's Disease (Spirochaetosis Icterohaemorrhagica) in the British Army in Flanders, *Lancet*, January 27th, 1917.

[19] Sir William Osler: *The Principles and Practice of Medicine*, 8th edition, p. 26.

[20] Blankenhorn: *Transactions* of the Association of American Physicians, 1917.

[21] C. E. Cooper Cole, Lieut.-Colonel C.A.M.C.: Preliminary Report on the Influenza Epidemic at Bramshott in September and October, 1918, BRITISH MEDICAL JOURNAL, November 23rd, 1918.

[22] Sir Wilmot Herringham: Special Clinical and Scientific Meeting of British Medical Association in London, on April 10th, 1919. Discussion on Influenza, BRITISH MEDICAL JOURNAL, April 19th, 1919.

[23] Osler: Ibid., p. 359.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

EFFICIENT TREATMENT OF THE CHRONIC RUNNING EAR.

THE following remarks are based upon an experience of three and a quarter years in the army in charge of an aural clinic in Egypt and at home. In Egypt I was allowed seventy beds and an out-patient department, and the experience has convinced me of the futility of our previous methods of treating otorrhoea; in the future some more generous provision of in-patient treatment must be made on a large scale if we are to increase the efficiency of the enormous numbers of partially deaf attending out-patient departments. Especially is this desirable in the case of children. The aural work in Egypt was admirably organized by Lieut.-Colonel Sir J. W. Barrett, R.A.M.C., the consulting aurist, and to its almost complete success I ascribe the rapid reduction in the number of beds required. Essentially it consisted of the following routine:

1. All cases of otorrhoea were in the first instance admitted to a hospital for treatment by an aural specialist with a trained nursing staff.

2. Routine treatment to the ear was given at least twice daily by a nurse specially trained for the work; in certain cases the patient remained in bed and cleaned his own ear every fifteen minutes or so. All granulations or any other obstruction to free drainage were previously removed by the aural specialist.

3. If there was doubt as to retention of pus in the mastoid the patient was kept in bed on a light diet; the temperature was taken every two hours, and blood examinations were made. Syringing was only allowed in special cases. In a few cases an *x*-ray photograph was taken. In nearly every case under treatment by mopping up discharge down to the drum and the insertion of antiseptic drops, the discharge diminished until it entirely disappeared or only a little mucus persisted.

4. When the patient left hospital he was given antiseptic drops for his own use and taught to clean his own ear down

to the tympanic cavity. His medical officer was requested to return him to the hospital in which he had been treated if any untoward symptoms should occur.

During the whole of my experience of this routine I do not recollect a single patient requiring a mastoid operation after the routine treatment had once been commenced and properly continued. Without exception, the only patients requiring interference with the mastoid region were instances of men who had not reported sick with their ears, and so had been carrying on with an untreated discharge. Usually these were very acute and extensive cases, and streptococcal in origin.

Rather against our previous opinions the conclusion was forced upon us that chronic otorrhoea is not the dangerous condition commonly supposed, if efficiently treated. Such treatment often necessitates a short period in bed in the first instance, with skilled attendance; in very few cases need the mastoid be drained. My experience is utterly against the contentions of those who have recently advocated almost routine drainage of the antrum, holding, as they do, that chronic otorrhoea is perpetuated by a chronic infection of the mastoid antrum. In my opinion, it is the treatment by rest in bed and the high standard of surgical cleanliness necessitated by sojourn in a hospital or nursing home bed that accounts for the success of these "modified" mastoid operations. On the other hand, conservation of the middle-ear structures is rightly replacing a haphazard scraping away of all the contents of the tympanum, and as such is very much to the good when there is actually a purulent affection of the mastoid region.

The complete and radical mastoid operation should not be performed as a routine—the indications are few; and the occurrence of mastoiditis in the course of chronic otorrhoea of the usual type of sepsis is most emphatically not such an indication.

WILLIAM WILSON, M.D., B.Sc.,
Late Aural Specialist E.E.F., and o/c Aural Centre, R.A.M.C., Blackpool.
Manchester.

SURGICAL TREATMENT OF A CASE OF ECLAMPSIA.

MRS. H., aged 42 years, was admitted to the Oldham Union Infirmary on February 17th, 1919, for pregnancy complicated by eclampsia. She had had one convulsion before admission. On admission she was very restless and incoherent, and quite unable to give any account of herself. The urine contained a very large amount of albumin. The treatment consisted of enemata, rectal salines, and hot packs, and no further convulsions occurred until after a normal delivery, on February 19th, of a full term female child.

Soon after confinement the patient became very restless, and began to have convulsions, which became gradually more frequent until she was having them every few minutes. Morphine, pilocarpine, and other methods of eliminating the toxins were tried, but, as the patient's condition became steadily worse, it was decided to operate. On the evening of February 22nd, Dr. Radcliffe, the visiting surgeon, performed decapsulization and nephrotomy of both kidneys, which were found to be in a condition of parenchymatous degeneration, being large and white. From the time of operation the patient's condition, mental and physical, steadily improved. No more convulsions occurred, and she is now ready for discharge, the urine being free from albumin, and her mental condition normal.

I wish to thank Dr. Robert P. Parker, the superintendent medical officer, for permission to publish the notes of this case.

MARY G. CARDWELL, M.B., Ch.B.,
Resident Assistant Medical Officer.
Union Infirmary, Oldham.

THE foundation stone of the great Victoria Hospital in Rome was laid on April 28th in the presence of the King and Queen of Italy and a number of Ministers, Senators, Deputies, the Syndic of Rome, and other officials. The stone bears the following inscription: "Victor Emmanuel III Rex Italiae lapidem auspicalem nosocomii a victoria excitandi sollemni ritu statuit iiii Kal. Maias Anno MCMXIX." The hospital, which is situated at Monteverde, will cover an area of about 200,000 square metres. It will at first contain a thousand beds; later this number will be increased to fifteen hundred.

Reviews.

SURGERY OF THE ENTERIC GROUP OF DISEASES.

WITH that felicity for epigrammatic phrase which is so peculiarly his own, Sir William Osler, speaking at the recent annual dinner of the British Medical Association, referred to typhoid fever as the "great killer," and expressed his opinion that one of the greatest medical wonders of the war was that this enemy had been reduced to impotence. In the British armies in France the enteric fevers have been almost a negligible factor in the sick incidence from the numerical point of view, and the success which has attended the work of preventive medicine constitutes a triumph. In the French armies typhoid fever was a very serious menace until wholesale inoculation was introduced. Further, whilst epidemics of the disease spread among the civilian population in the areas occupied by the British troops, our army, thanks to the protection afforded by inoculation, remained practically free.

Of the cases which occurred amongst our own troops a very considerable number were treated in the Boulogne base, and it was a study of these cases which furnished the material on which Colonel WEBB-JOHNSON has based his book on the *Surgical Aspects of Typhoid and Paratyphoid Fevers*.[1] A consecutive series of 2,500 cases, the nature of which was established either by bacteriological examination or by agglutination tests, was studied, and the surgical complications occurring among them formed the author's starting-point. Happily he was not content to place on record merely his own observations, but has drawn also upon the available surgical literature, with the result that he has given in compact form a very comprehensive account of the protean manifestations of the enteric infections.

In a brief historical sketch he states that enteric was first noted as a military scourge in the civil war of 1603. John Hunter, acting as a military surgeon in the Seven Years' War, met with cases of fever with intestinal ulceration; many of his specimens are still preserved, and some of them are illustrated here. To W. W. Keen of Philadelphia, however, the credit is ascribed for first writing on the surgical complications of typhoid, in his book published in 1898.

The fundamental bacteriological knowledge on which the modern conception of the enteric fevers is based, and the subdivision of the "Group" into typhoid, paratyphoid A, and paratyphoid B, is succinctly stated. These three infections, clinically and pathologically similar, differ in severity, paratyphoid A being on the whole less severe than paratyphoid B, and the latter than typhoid. The distinction can only be definitely determined by the bacteriologist, and the war has proved the great value of Dreyer's method of agglutination. Speaking generally, cases of typhoid seen in France were less severe than those met with in civil practice, for the disease was in the majority of cases modified by inoculation. But inoculation, whilst modifying the severity, does not alter the broad characteristics of the disease, a point which was not sufficiently considered by those who, in the early days, regarded trench fever as typhoid modified by inoculation, whereas in certain salient points it differs.

The fact that typhoid is a bacillaemia is duly emphasized, and it is pointed out that this fact explains the widespread complications, since every organ in the body has been exposed to a bacillus-infected blood stream. The specific bacillus has been recovered from many infected regions, the recovery being more likely when the complication arises late in the course of the disease.

An interesting table detailing, under twenty-eight headings, the surgical complications, shows the incidence of each in the three members of the "group" and their comparative frequency in inoculated and uninoculated men. The figures will well repay careful study by those who desire statistical proof of the value of inoculation.

Colonel Webb-Johnson then deals with the complications as they arise regionally. He advises the administration

[1] *Surgical Aspects of Typhoid and Paratyphoid Fevers.* By A. E. Webb-Johnson, D.S.O., M.B., Ch.B.Vict., F.R.C.S. London: Henry Frowde, and Hodder and Stoughton. 1919. (Demy 8vo, pp. 190; 26 figures. 10s. 6d. net).

death is a loss to the medical profession of Manchester and to the science of cardiology. Many friends mourn his death, and the deepest sympathy is felt with his widow.

The Services.

THE INDIAN MEDICAL SERVICE.

ACTING RANK COUNTING FOR PENSIONS.

OFFICERS of the Indian Medical Service holding the temporary ranks and appointments in the field as D's.M.S. with the acting rank of surgeon-general, or D.D's.M.S. with the acting rank of colonel, are to be permitted to count service therein towards the additional pensions for which surgeon-generals and colonels respectively are eligible after certain periods of active employment in permanent appointments. Such services need not be continuous.

HONOURS.

ALBERT MEDAL.

SURGEON LIEUTENANT COMMANDER E. L. ATKINSON, D.S.O., R.N., has been awarded the Albert Medal for gallantry in saving life at sea. The following is the official record of the courageous act for which the distinction has been conferred:

On September 16th, 1918, a serious explosion occurred amidships on board H.M.S. *Glatton* whilst lying in Dover Harbour. This was followed immediately by an outbreak of fire, the oil fuel burning furiously and spreading fore and aft. Efforts were made to extinguish the fire by means of salvage tugs. The foremost magazines were flooded, but it was found impossible to get to the after magazine flooding positions. The explosion and fire cut off the after part of the ship, killing or seriously injuring all the officers who were on board, with one exception. The ship might have blown up at any moment. At the time of the explosion Surgeon Lieutenant Commander Atkinson was at work in his cabin. The first explosion rendered him unconscious. Recovering shortly, he found the flat outside his cabin filled with dense smoke and fumes. He made his way to the quarter deck by means of the ladder in the warrant officers' flat, the only one still intact. During this time he brought two unconscious men on to the upper deck, he himself being uninjured. He returned to the flat, and was bringing a third man up, when a smaller explosion occurred whilst he was on the ladder. This explosion blinded him, and at the same time a piece of metal was driven into his left leg in such a manner that he was unable to move until he had himself extracted it. Placing the third man on the upper deck, he proceeded forward through the shelter deck. By feel, being totally unable to see, he here found two more unconscious men, both of whom he brought out. He was found later on the upper deck in an almost unconscious condition, so wounded and burnt that his life was despaired of for some time.

FOREIGN DECORATIONS.

The following decorations and medals have been conferred by the King of Italy in recognition of distinguished services rendered during the course of the campaign:

Silver Medal for Valour.—Captains John Edwin Allan and William Eidinow, R.A.M.C.(S.R.)

Bronze Medal for Valour.—Captain (acting Major) George R. E. G. Mackay, M.C., R.A.M.C.(T.F.), and temporary Captains Francis J. A. Keane and John T. Lloyd, M.C., R.A.M.C.

Croce di Guerra.—Major-General Foster R. Newland, C.B., C.M.G., Lieut.-Colonels (temporary Colonels) Samuel A. Archer, C.M.G., R.A.M.C., and Ransom Pickard, C.M.G., R.A.M.C. (T.F.), Captain (acting Lieut.-Colonel) Ralph A. Broderick, D.S.O., M.C., R.A.M.C.(T.F.), Captains (acting Majors) Thomas D. Inch, O.B.E., M.C., R.A.M.C., Treffry Owen Thompson, R.A.M.C., Captain Robert L. Newell, R.A.M.C.(S.R.), Captain Oskar Teichmann, D.S.O., M.C., R.A.M.C. (T.F.Res.), temporary Captains Henry E. M. Baylis, R.A.M.C., James M. Christie, R.A.M.C., Ambrose Emerson, R.A.M.C.

The Emperor of Japan has conferred the Order of the Rising Sun (4th class) on Colonel William Robert Smith, R.A.M.C.(T.F.).

Surgeon Rear-Admiral J. J. Dennis, C.B., has been appointed a Commander of the Order of the Crown of Belgium, in recognition of valuable services rendered in the allied cause.

The name of Surgeon-Major Luke Gerald Dillon, M.D., has been mentioned by the Secretary of State for War for valuable services rendered in the United Kingdom in connexion with the war.

Universities and Colleges.

UNIVERSITY OF CAMBRIDGE.

AT a congregation held on May 16th the degree of Doctor of Medicine was conferred upon E. N. Russell.

On the same date a grace favouring compulsory science in the previous examination was rejected.

LONDON INTER-COLLEGIATE SCHOLARSHIPS BOARD.

Entrance Scholarships and Exhibitions, 1919.

SEVENTEEN medical entrance scholarships and exhibitions of an aggregate total value of about £1,550, tenable in the Faculty of Medical Sciences of University College and King's College, and in the medical schools of Westminster Hospital, King's College Hospital, University College Hospital, the London (Royal Free Hospital) School of Medicine for Women, and the London Hospital, will be offered for competition on Tuesday, July 1st, and not on July 15th as originally arranged. Particulars may be obtained from the Secretary of the Board—Mr. S. C. Ranner, M.A., Medical School, King's College Hospital, Denmark Hill, London, S.E.5.

CONJOINT BOARD IN ENGLAND.

THE diplomas of L.R.C.P. and M.R.C.S. have been conferred upon the following candidates, who have passed the final examination of the Conjoint Board and complied with the by-laws of the Colleges:

J. H. Allan, B. A. Astley-Weston, Marjorie Back, C. W. Bennett, H. Buck, E. E. Carter, R. A. Cooke, Idris Davies, W. S. Dawson, T. H. Dobrashian, Lucien Dublé, Dwijendra Nath Dutt, Sylvia V. Elman, F. A. Evans, J. Fanning, D. H. Geffen, R. B. Gibson, J. Gilmour, P. E. Gorst, St. G. B. D. Gray, Gwenvron M. Griffiths, Margaret Hammond, B. C. Hardiman, W. R. G. Harris, C. B. Henry, A. R. Hill, T. L. Hillier, F. G. Hobson, C. O. Hudson, R. Jenner-Clarke, Hassan Kamal, Muriel M. Kenworthy, Madari Andia Keshvalu, P. B. Kittel, A. O. Knight, J. N. Leitch, Lillian Lowenstein, L. Lyne, S. D. McAusland, J. J. M. MacDonnell, W. K. McKay, E. D. Macmillan, Girdharlal Tejpal Mody, C. F. Newman, J. L. Nisbet, D. O'Donovan, J. L. C. O'Flyn, E. R. Peirce, F. L. Pickett, Norah D. Pinkerton, Lillie M. Pinson, W. Reikan, Hilda W. Richards, W. A. Richards, J. C. R. Richardson, E. D. T. Roberts, H. S. Robinson, J. S. Rogers, H. T. Roper-Hall, J. C. Russell, R. J. Saunders, A. E. Sawday, M. L. Schroeter, E. L. Sergeant, E. N. Showell-Rogers, W. S. Sykes, G. B. Tarring, A. C. Teuten, A. H. Turton, E. R. Webb, D. E. Wijewardene, S. C. de S. Wijeyeratne, S. Wolff, M. Wong, W. Worger, A. E. Young.

Medical News.

MR. G. E. GASK, C.M.G., D.S.O., F.R.C.S., having completed his service in France, has returned to civil practice in London, and Major J. J. COX, M.D., late Commissioner of Medical Services, North-West Region, to Manchester.

AMONG those who have recently been called to the Bar are Major H. J. Milligan, M.C., R.A.M.C., and Captain F. J. Henry, M.C., R.A.M.C., both of Glasgow University and Gray's Inn.

THE trustees of the British Museum have elected Sir Norman Moore, Bt., President of the Royal College of Physicians of London, a member of the standing committee.

THE governors of St. George's Hospital have abandoned the proposal to sell the hospital and rebuild elsewhere, and have decided to rebuild the hospital on the present site.

THE Hertfordshire Local Medical and Panel Committee invite medical practitioners to attend a special meeting at Hatfield on Tuesday next, May 27th, at 2.45 p.m., when Dr. Brackenbury will give an address.

DR. F. A. BAINBRIDGE, professor of physiology in the University of London, and Dr. G. S. Graham-Smith, lecturer in hygiene in the University of Cambridge, have been elected Fellows of the Royal Society.

THE King of the Belgians has conferred the honour of officer of the Order of the Crown of Belgium upon Dr. H. E. Cuff, O.B.E., principal medical officer, Metropolitan Asylums Board, in recognition of valuable services rendered in the allied cause.

DR. SEPTIMUS SUNDERLAND has received from the French Ambassador in London the decoration of Chevalier de la Légion d'Honneur in recognition of his many years of valuable service as physician to the French Hospital and Dispensary, Shaftesbury Avenue.

THE *Bulletin international*, a quarterly review which for forty-nine years has published reports of the international committees of the Red Cross, will become a monthly periodical with the title of *Revue internationale de la croix rouge*.

THE Prince of Wales has become president of the Royal Dental Hospital of London, Leicester Square, to show his appreciation of the work of the hospital since August, 1914; in this period over 350,000 operations were performed.

THE Royal Faculty of Physicians and Surgeons of Glasgow has adopted a resolution expressing the opinion that the Dogs' Protection Bill, if passed into law, would seriously impede the progress of exact medical knowledge. Copies have been sent to the Home Secretary and members of Parliament for Scotland.

DR. HAROLD PRINGLE, lecturer on histology and assistant in the department of physiology in the University of Edinburgh, has been appointed professor of physiology in Trinity College, Dublin, in the room of the late Sir Henry Thompson, who was drowned at sea when the *Leinster* was sunk in the Irish Sea last October.

THE post of Director-General of the League of Red Cross Societies, founded this month at the conference of Red Cross Societies in Paris, has been accepted by Lieut.-General Sir David Henderson, K.C.B., D.S.O., who was Director-General of Military Aëronautics from 1913–18.

THE Glasgow University Club is resuming its activities after the war. The Club dines at the Trocadero Restaurant on Friday next, May 30th. The Right Hon. Sir Robert S. Horne, Minister of Labour, will be in the chair. Further information can be obtained from Dr. David Roxburgh, honorary secretary, 30, Seymour Street.

DR. GRAHAM LITTLE has accepted an invitation to open the discussion on lichen planus, the subject chosen for general discussion at the meeting of the American Dermatological Association at Atlantic City in June. The meeting is to be held the same time as the American Congress of Physicians and Surgeons, of which the Dermatological Association forms a component part.

THE President of the Local Government Board has appointed Lieut.-Colonel Sir Shirley F. Murphy, F.R.C.S., R.A.M.C.(T.), some time Medical Officer of Health, Administrative County of London, at present attached to the London Command, to represent His Majesty's Government at the forthcoming congresses of the Ontario Medical Association and the American Medical Association to be held at Toronto and Atlantic City respectively.

THE accounts presented at the usual monthly meeting of the committee of the Medical Sickness, Annuity, and Life Assurance Friendly Society on May 16th showed a considerable decrease in the influenza claims. The experience of chronic claims on those in half pay was below the expectation, and had been gradually falling for some years, thus proving that the strict medical examination of new proposers was beginning to tell in the society's favour. The return of medical men to their practices from army service has resulted in a large increase of new business. The new scheme of sickness insurance for medical women had been favourably received. This is believed to be the first serious attempt to establish a permanent protection against sickness and accident for women practitioners. The society does not charge any extra premium for war risks on either life or sickness rates. Particulars of the society's work can be obtained from the Secretary, 300, High Holborn, W.C.1.

Letters, Notes, and Answers.

In order to avoid delay, it is particularly requested that ALL letters on the editorial business of the JOURNAL be addressed to the Editor at the Office of the JOURNAL.

The postal address of the BRITISH MEDICAL ASSOCIATION and BRITISH MEDICAL JOURNAL is 429, Strand, London, W.C.2. The telegraphic addresses are:

1. EDITOR of the BRITISH MEDICAL JOURNAL, *Aitiology, Westrand, London*; telephone, 2631, Gerrard.
2. ACTING 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.

QUERIES AND ANSWERS.

"AJAX" asks for suggestions for the relief of severe lightning pains in a patient with locomotor ataxia. Many drugs have been tried without benefit.

HOME FOR BLIND GENTLEMAN.

"A.T." desires to hear of a home where a blind gentleman, aged between 50 and 60, able to contribute 25s. a week, would be received. He has lived twenty years in a village, but the after-war conditions make matters difficult for him.

*** We have had, on this question, the advantage of the advice of Mr. Henry Stainsby (Secretary-General of the National Institute for the Blind). He writes that he knows of no home unless the blind man can pay from £2 to £3 a week, and adds: "A single person could live quite comfortably in a country village on 25s. a week despite these abnormal times. I should suggest, therefore, that the man return to the village which he knows so well and in which he is so well known, there to live a normal life."

SWIMMING FOR CHILDREN.

MR. WALTER EDMUNDS (London, W.1) asks for experience as to (1) the age at which healthy children should be taught to swim; (2) the best way to teach them; (3) the smallest bath in which they can be taught. The head master of a London County School, Mr. Edmunds writes, recently stated that all his boys over 9 years of age could swim. The concrete open-air swimming bath which some residential schools have is only of use in summer. An indoor warm water bath like that at the Tooting Special Military Hospital, described by Dr. Buzzard last week (p. 610), seems, Mr. Edmunds thinks, much better. The sea, even when available, is not, he suggests, very suitable for the purpose; the state of the tide does not often fit in with school routine. After learning to swim in fresh water, a boy would enjoy sea bathing much more than if he could not swim.

STYRIAN ARSENIC EATERS.

H. F. W.—Sir Thomas Oliver informs us that there is little to add to the account he gave of this matter in his article on arsenic in *Allbutt's System of Medicine*, vol. ii, Part I, but he has been good enough to give the following information: "The form in which the arsenic is taken is as *huttereich*, a mineral substance rich in arsenic, 6 grains as a dose, gradually increased; it is taken also as orpiment (arsenic trisulphide), 2 grains for a dose at first. It is taken chiefly by males as a tonic and to improve the respiratory powers; it is said also to increase sexual desire and ability. Arsenic eaters in Styria, after they have gradually accustomed themselves to the drug and acquired immunity, have a longevity equal to the non-arsenic-eating population. There is no evidence that the arsenic eaters of Styria are more prone to cancer than others of the non-arsenic-eating population. In Great Britain the late Sir Jonathan Hutchinson found skin cancer follow after prolonged courses of treatment by arsenic; so, too, Sir Clifford Allbutt." From Sir Thomas Oliver's article it appears that the drug is taken at intervals of a few days, and that a local royal commission reported that the frequency of the practice had been grossly exaggerated.

LETTERS, NOTES, ETC.

MEDICAL RESETTLEMENT.

"EX-CAPTAIN R.A.M.C." writes: On joining the army I was informed by circular from the London Insurance Committee that men on my list who joined the army would be reinstated on my list automatically on their return to civil life, in accordance with a scheme agreed upon between the London Insurance and Panel Committees *and the Insurance Commissioners*. I now find this has been cancelled, with the result that a number have signed on with other doctors in my absence and wish to transfer to me. With the multiplicity of bodies looking after our interests, I think panel practitioners in the army should have been so informed, as many might not have signed on again. At the same time it does not lessen our sense of gratitude to the men at home who "carried on" under many adverse circumstances.

BENZOL FOR MOTOR CARS.

DR. W. J. YOUNG (Harston, Cambridge) writes: Mr. Massac Buist in his recent article suggested trial of a mixture of two parts petrol and one benzol. After trial I am able to recommend a mixture of half and half. The engine runs more sweetly, power is greater, mileage per gallon is increased and cost is lessened. My Napier, which would hardly move on the bad petrol of last winter, did quite nicely on the two to one mixture, and now runs quite admirably on half and half; my Ford revels in this mixture. As the engine heats more, the cooling apparatus must be looked to, the spark kept well advanced and plenty of air given. Benzol is said to have a tendency to "soot up"; the preventive is again plenty of air, which means also economy and efficiency.

*** The Automobile Association informs us that it is compiling a list of retailers stocking benzol; it invites motorists desiring information to communicate with the Fuels Department, A.A. and M.U., Fanum House, Whitcomb Street, London, W.C.2.

FAILURE TO NOTIFY OPHTHALMIA NEONATORUM.

AT the Newcastle-on-Tyne police court, on May 16th, a medical man was summoned on information laid by the medical officer of health charging him with having unlawfully and wilfully neglected to obey a regulation of the Local Government Board requiring notification of ophthalmia neonatorum. Mr. Molineux pleaded "guilty" on behalf of the defendant, who did not appear. The deputy town clerk, who prosecuted, said that the child was born prematurely; a certified midwife was in attendance and the defendant was called in later. Four days after the birth the midwife noticed a discharge from the child's eyes and the doctor's attention was drawn to this. Subsequently the child was taken to the defendant's surgery when he was out, and when the mother saw him later he ordered the child to be taken to the Eye Infirmary. The left eye was then totally gone and there was little hope of saving the other. The defendant, in a letter of explanation to the M.O.H., said he did not attend the child, and only looked in now and again when he was passing. He ended, "As it was not a case for me, I did not notify you, but at the same time if it had been, I was not aware that such cases had to be notified." In view of the notices sent out to all practitioners in the city by the M.O.H., the prosecution held that no one could be unaware of the obligation of a medical man to notify this disease. Dr. A. S. Percival, surgeon to the Northumberland and Durham Eye Infirmary, at the request of the magistrates, described the condition of