been proved susceptible but were not injected had to be discharged before it was possible to finish the investigation.

After the first dose only 2 patients of the 38 showed any marked reaction, either local or general. One was a boy, aged 8, who had an inflamed and painful arm for three days, but showed no general symptoms. This boy had no reaction after the two subsequent injections. The second was a girl, aged 7, who also had no general symptoms, but a well marked local reaction; she had both local and general reactions after the second dose.

After the second dose 5 patients had severe local reactions. The girl just mentioned above was kept awake all night with the pain in her arm, and had a temperature of about 100°; it became normal in twelve hours. Another girl also cried for some hours during the night with a painful arm, and six hours after the injection fainted in bed, although she had been kept recumbent all the time. Her temperature then rose to 100.8° (pulse 130, respirations 34), and ten hours after the injection was 102.2° (pulse 130, respirations 36). After this the temperature, pulse, and respirations gradually became normal, and by the next day the child seemed perfectly well. Two of the remaining five patients with local reactions had temperatures just under 100° for a few hours, but no other symptoms.

After the third dose none of the patients had any local or general reaction worth mentioning.

Second Schick Reactions.

The 38 patients who had been immunized with toxin-antitoxin were then tried with the Schick test again. Two of these still gave a definitely positive result, although the reaction was less marked than previously; 8 gave negative and pseudo reactions, 4 of these being in children under 5 years of age. The remaining 28 did not react at all, and were therefore presumably immune.

Summary.

Of 103 persons 32 were apparently susceptible to diphtheria. An endeavour was made to immunize 38 patients, including 10 patients under 5 years of age: 36 of these patients failed to respond to the Schick test, and probably therefore had been rendered immune.

ACUTE PUERPERAL COMPLETE INVERSION OF THE UTERUS: REPLACEMENT: RECOVERY.

BY

I. S. FOX, M.B., CH.B.,

CHESTER.

ACUTE complete inversion of the uterus is an accident happily seen only rarely in modern obstetrical practice. According to Beckmann[1] not a single case occurred in the course of 250,000 labours in the St. Petersburg lying-in hospital, only one case was reported among 190,833 deliveries in Dublin, while Thorn[2] collected only 641 cases from the literature of the entire world. The average incidence, however, of this condition is no doubt underestimated by a study of the statistics collected from large obstetrical clinics in which all possible precautions are taken, and it is probably more common in private practice, in patients cared for in their own homes, and by accoucheurs less skilled in the practice of obstetrics. The following case came under my observation when I was assistant resident medical officer to the Brownlow Hill Infirmary, Liverpool.

A multipara, aged 30 years, was delivered by forceps in her own home at 10.15 a.m. on March 21st. The labour was not remarkable; the placenta was presumably expressed by Credé's method. The midwife in attendance reported that there had been no excessive haemorrhage, although the patient subsequently stated that she had bled profusely and had passed large clots all that afternoon. In the evening there was considerable abdominal pain, which kept the patient awake all night. In her own words, "there was also a sense of something slipping down inside, which felt like the head of another baby coming through." At about 6 o'clock the following evening the patient suddenly collapsed; a doctor was called, and ordered her immediate removal to hospital.

On admission the patient was in an extremely collapsed condition, and obviously suffering from profound shock. She was quite unconscious, blanched, pulseless at both wrists, not restless, and her respirations very shallow. Completely outside the vulva was a mass about the size of a small coco-nut, in appearance exactly like a placenta with its uterine surface presenting. The usual means of combating shock were immediately taken: the foot of the bed was raised, the lower extremities were bandaged, and hot-water bottles utilized. In addition, strychnine was administered hypodermically, followed by ether intramuscularly. The pulse then became just palpable, and one pint of saline was transfused intravenously through the basilic vein. The pulse gradually improved, and consciousness was restored, but the patient still looked exsanguinated, in spite of the fact that there was no visible bleeding. At 10 p.m. more strychnine was administered hypodermically, and the uterus was then examined. Abdominally the hypogastrium was soft, and instead of the protuberance of the usually hard uterus a depression was noted. The "placental" mass outside the vulva was found to be distinctly pyriform in shape, with its broad end outside the vulva, and its apex firmly embraced by the cervix, whose collar-like circumference was easily palpable. The fundus could not be felt either anteriorly or posteriorly, and the walls of the vagina were normal. Reposition was easily effected manually without an anaesthetic by gently compressing the narrow end and pushing it through the cervical os. Digital dilatation of the os was found necessary before the fundus could be replaced. The fundus was then palpable by the hand on the abdomen; a hot douche was ordered and the vagina packed. At this stage the pulse was 160, temperature 97°, and respirations 28. The patient passed a fairly comfortable night, and appeared much better in the morning, but as the lochia were offensive 30 c.cm. of antistreptococcal serum was given. The temperature remained 101°-99.6° for two days, and on the third day the patient was anaesthetized and a tube was inserted into the uterus by Mr. Leyland Robinson. Eusol douches were given through this tube night and morning. Recovery was now uneventful.

The interesting features of this case are, to my mind: (1) the extreme gravity of shock; (2) the immediate good results of transfusion; (3) the ease with which the uterus could be replaced.

REFERENCES.

[1] Beckmann: Zur Aetiologie der Inversio Uteri post Partum, *Zeit. f. Geb. u. Gyn.*, 1895, xxxi, pp. 371-401.

[2] Thorn, W.: Zur Inversio Uteri, *Samml. klin. Vortr.*, Leipzig, 1911.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

PERINEAL PROSTATECTOMY.

A METHOD I have used for some time now in removing a prostate by the perineal route, and which I have found very satisfactory, is the following:

The bladder is washed out with warm boracic lotion several times, and an ounce or two left in. The patient is then placed in the lithotomy position and a curved prostatic staff is inserted into the bladder. The scrotum being kept out of the way and the staff held in place, the prostate is reached by the usual perineal dissection—namely, exposure and retraction forward of the transversus perinei muscles, deeper dissection posteriorly bringing into view the lower part of the prostate and the recto-urethralis muscle, which is divided transversely, the necessary care being taken to avoid injury to the anal canal and lower part of the rectum, which is gently separated from the posterior aspect of the prostate. A good light is necessary, and a head-lamp is sometimes useful.

The point of one blade of a pair of scissors is now thrust into the groove in the staff through the membranous urethra at its junction with the prostate, and a cut made directly through the substance of the prostate and the capsular sheath on its postero-inferior aspect for about half an inch, the rectum being kept well out of the way.

A Teale's gouget is now gently but firmly pushed along the staff into the bladder and the staff withdrawn. There is here an escape of the remaining fluid in the bladder. The gouget, which tends to split the prostate, is now withdrawn, and the forefinger inserted in its place. The gland can now in most cases be easily shelled out in two or more pieces through the opening in the posterior and lower part of its capsular sheath which had been previously divided. The more "obstinate" portions may be twisted out with a stout pair of forceps.

The end of a six-inch by half-inch rubber tube with a lateral "eye" is inserted into the bladder, and the other end brought out through the wound, which is now closed interruptedly and the tube anchored by a stitch or two of silkworm gut. This end is clamped and the patient put back to bed, where the clamp is removed and a long rubber drainage tube is connected to it and led over the side of the bed into a basin or bucket.

The bladder is washed out two or three times a day, and the tube withdrawn on the third day and the patient allowed out of bed, the wound and perineum being well supported with

wool and an oiled silk dressing. Thereafter a full-sized rubber or gum-elastic catheter is passed daily per urethram until the urine comes freely and naturally.

For the smaller and firmer prostates, and not only for the small hard fibrous prostate of textbook fame, I have found this a very satisfactory method. I have never seen a case of severe haemorrhage such as sometimes so alarmingly occurs in the suprapubic operation. Drainage is excellent and convalescence rapid. To those familiar with perineal anatomy and surgery this method is easy and swift, and can be conveniently done under spinal anaesthesia.

There are two contraindications to the use of this method—namely, one where the gland is very large and its several portions cannot be conveniently removed through the opening in the sheath without at the same time causing injury to the membranous urethra and its compressor muscle; the other when it is necessary to drain the bladder prior to removal of the gland, as, although the drainage is ideal in itself, the length of time during which this is necessary makes it very uncomfortable for the patient; and what is more important is the fact that it is very difficult to re-expose the parts satisfactorily after they have been interfered with, although I have done this on several occasions.

This method differs in two essentials from Young's accepted operation:

1. Instead of splitting the whole of the fascial sheath on the posterior surface of the prostate only a comparatively small portion is opened, and so leaves the prostatic bed more or less intact—a feature of suprapubic prostatectomy.
2. No retractor for pulling down the prostate, such as Young's instrument, is necessary. This instrument is inserted into the bladder through the membranous urethra, and in this way and its manipulation thereafter causes unnecessary damage to the compressor muscle, the avoidance of which injury and the preservation of the function of this muscle being one of the principal objects in perineal prostatectomy.

Inverness. DONALD MACLEOD, F.R.C.S.

UNILATERAL OPTIC NEURITIS ASSOCIATED WITH FOLLICULAR TONSILLITIS AND ARTICULAR RHEUMATISM.

THE diagnosis in the following case was arrived at with difficulty, but seems to be confirmed by the result of treatment.

A schoolmistress, aged 21, first came to me on February 6th, 1924, complaining of having "gone blind in her left eye." The history she gave was that on the night of February 2nd she developed a worrying headache over the whole of the left side of the head, the pain being worst in the orbital region, and as she said "felt to be behind the eye." Vision with Snellen's test type was: left eye 6/60, right eye 6/6. The tension in both eyes was normal.

I instilled homatropine with cocaine, and when the pupil was fully dilated examined her in the dark room. I found very definite optic neuritis in the left eye. The inner half of the disc was congested and blurred. There was no retinitis and no exudation, and the vessels appeared healthy. I could discover no cause for this condition. I prescribed potassium iodide gr. v t.d.s. and advised her to wear smoked glasses. She saw me frequently and each time stated she saw no better but that the pain grew worse; she obtained temporary relief, however, from aspirin gr. v, taken when required. Since the condition remained much the same, on March 4th, following my advice, she saw Mr. A. L. Whitehead of Leeds, who confirmed the diagnosis but was uncertain as to the cause. He found no alteration in reflexes or sensation, no nystagmus, no ataxia, and no sign of any cerebral cause. The accessory sinuses were found to be healthy. Treatment with potassium iodide was continued until March 16th, when she complained of pain on movement of the left eyeball. I now thought there was some rheumatism in this clinical picture and forthwith prescribed sodium salicylate. Two days later I received a message to visit her and found her in bed feeling very ill, with well developed follicular tonsillitis. I treated her for this condition according to my usual custom, which is to give white mixture and a gargle containing glycerin and carbolic acid; I stopped the salicylate. The throat condition quickly responded, and in a week she had completely recovered from the tonsillitis. In a few days, however, she complained of pain and stiffness in the left ankle-joint, but there was no swelling or redness. I again prescribed sodium salicylate, and in a short time the pain in the ankle-joint had disappeared, as also had the pain in the head and eye. The vision, too, had improved. The patient continued to make rapid progress, and on April 20th I again examined the left fundus and found the disc had a perfectly normal appearance. The edges were cleanly cut and well defined. Her vision was now 6/6 in both eyes.

I venture to give the following as an opinion of the probable cause of the condition: that there was a septic focus concealed in one of the tonsillar crypts, that possibly exposure to cold, followed by a chill, lit up this focus in the tonsil which had hitherto remained quiescent and produced acute follicular tonsillitis, and that in the process of repair the above-mentioned focus had disappeared and so the tonsil had passed into a healthy state.

LIONEL W. BRADSHAW,
Barnoldswick, Lancs. L.R.C.S., L.R.C.P.

POST-MORTEM CRYING.

I HAVE been unable to find any previously recorded case of *post-mortem* crying, so the following notes may be of interest.

On March 3rd, 1923, I was called to a confinement. I had not had an opportunity of examining the mother before labour set in, but learnt subsequently that she had had one previous labour—a difficult instrumental delivery, the child being stillborn. I found a face presentation with the chin rotated into the sacral hollow. The patient was in a very exhausted condition, so I obtained the necessary assistance, perforated and crushed the head, and delivered with the cranioclast.

Whilst delivering the placenta the dead and decerebrate foetus was left on the end of the bed, and suddenly it took two or three deep gasping breaths and began to cry loudly. The crying lasted about two minutes.

The explanation is, I suppose, obvious; still this seems to me interesting from the medico-legal aspect. Had one performed a *post-mortem* examination on the body of the child one would have found the lungs very fully expanded, and the inference would have been that it had been born alive and then killed by savage violence to its head.

H. C. CRAVEN VEITCH,
St. Neots. M.R.C.S., L.R.C.P.

AN EXOSTOSIS OF THE SACRUM PREVENTING DELIVERY.

IN the following case the cause of the difficulty in delivery is probably unusual, but its main interest seems to me to lie in the prognosis for the infant.

I was called recently to a woman in hospital who had been in labour about fourteen hours; the membranes had ruptured ten hours before. The head was high up in the pelvis, the child lying in the left occipito-posterior position, with uterus tightly contracted. An exostosis of the sacrum, about the size of a walnut, was pressing on the left frontal region of the foetus. Under deep anaesthesia I was able to push the head back; there was a very audible click as the exostosis disengaged from the depression on the skull; then, having rotated the head, I was able with an effort to deliver with forceps. The child was born alive, but it had a large depression, about 3 inches in circumference and 1½ inches deep, on the skull.

Chester. A. MCMURRAY, F.R.C.S.Edin.

Reports of Societies.

ELUCIDATION OF CANCER.

A MEETING of the Section of Epidemiology and State Medicine of the Royal Society of Medicine was held on May 23rd, with Dr. MAJOR GREENWOOD, senior honorary secretary, in the chair.

The CHAIRMAN read part of a letter from the President-elect, Dr. John C. McVail, regretting his inability to be present owing to a long-standing engagement in Scotland, which prevented him from joining the Section "in recording the sense of the great loss which the science of epidemiology and all connected with it have sustained, and the admiration and affection which we all had for our president and friend," Dr. Richard J. Reece. A resolution was carried unanimously expressing the profound grief of the Section occasioned by the tragic death of its president, and its deep sympathy with Dr. Reece's family and colleagues.

Dr. LOUIS W. SAMBON read a paper entitled "The elucidation of cancer." The lecturer first gave an interesting account, illustrated by numerous lantern slides of classical sculptures, of the knowledge possessed by the ancient civilized races of malignant disease; he then indicated the analogies between cancer and certain diseases—such as elephantiasis—of parasitic origin, and described the field investigations he had recently carried out in part

Dr. J. H. Whitaker, medical superintendent of Grove Hospital, who examined the boy on his admission on September 12th, said there was not the slightest doubt that he was suffering from a severe attack of diphtheria and was in a critical condition. The boy died at 5 o'clock on the following morning. He had no difficulty in opening the boy's mouth, or in diagnosing diphtheria. In cross-examination, Dr. Whitaker agreed that the symptoms were rather misleading.

Counsel: I might put it that the symptoms were not the ordinary symptoms of diphtheria?—I think you might.

His Honour: Is it difficult to diagnose diphtheria?—At times it is.

Dr. Savory, cross-examined, was asked at what stage he first knew the boy had got diphtheria.—I did not know he had got it.

Counsel: This boy was dying in front of your eyes from diphtheria and yet you were not able to diagnose it?—I am prepared to admit that I was mistaken.

His Honour: Can you explain how Dr. Whitaker was able to diagnose diphtheria when you were not able to do so?—Yes. In a hospital you have plenty of light and appliances, as many nurses as you like, and every facility for making whatever examination you wish to make.

His Honour, giving judgement for the plaintiff, said that, without casting any slur on Dr. Savory's capacity and abilities as a doctor, he thought in that case the doctor did unfortunately fail to exercise that skill which was incumbent upon him. The defendant had said that it had never entered his head to take a swab of the boy's throat. Therefore, the defendant had made up his mind that this boy was not suffering from diphtheria, and, consequently, thought it was unnecessary to take those precautions which he ought to have taken. The defendant also ought to have taken the boy's temperature.

The rule of law laid down by the Court of Appeal in Clark *v.* London General Omnibus Company, Ltd. (1906), 2 K.B., *b* 48, is:

"That a father cannot recover, either at common law or under the Fatal Accidents Act, 1846 (Lord Campbell's Act), the funeral expenses to which he has been put in burying an unmarried infant daughter whose death was caused by reason of the defendant's negligence and who was residing with her father at the time of her death."

The Court of Appeal, in that case, approved the majority decision in Osborn *v.* Gillett (1873), L.R. 8, Ex. 88—interesting because it contains a dissenting judgement by Bramwell, B., who cited R. *v.* Vann (21 L.J., M.C., 39), in which a board of guardians recovered funeral expenses incurred in burying a child where the father had means. It is true that R. *v.* Vann was followed in Bedwell *v.* Golding (1902), 12 T.L.R., where a father was held entitled to recover the funeral expenses of his daughter on the ground that he was bound to bury her, but in Clark's case, Alverstone, C.J., said: "I differ from Phillimore, J., in Bedwell *v.* Golding"—so that that case may be regarded definitely as over-ruled.

Again and again it has been laid down that in a civil court the death of a human being cannot be complained of as an injury, and when Alverstone, C.J., in Clark's case, said: "The course of authority is far too strong to justify us in saying that an action to recover funeral expenses will lie under that Act"—the Fatal Accidents Act—he might have added at common law also, for Kennedy, L.J., in that remarkable case Jackson *v.* Watson and Sons (1909), 2 K.B., 198 (where a husband recovered damages for breach of warranty under the Sale of Goods Act, the death of his wife being allowed to form "only an element in ascertaining the damages arising therefrom"), said at page 205:

"The case of Clark *v.* London General Omnibus Company binds us to hold that where a person's death has been caused by the actionable conduct of another, although if the deceased person had been injured only and not killed he would have been entitled to sue the wrongdoer for the damage occasioned to himself by the wrongful act, no one, whatever his connexion with the deceased may be, can maintain an action of tort for damage resulting to himself from the death in regard either to the payment of funeral expenses or to loss of service, except in regard to loss of service in circumstances to which the provisions of the Fatal Accidents Act, 1846, in favour of a wife, husband, parent, or child are applicable. The loss recoverable as damages from the tortfeasor under that Act must be one arising out of a relationship, and not merely from the determination of a contract; it may be sufficiently evidenced by a reasonable expectation of pecuniary benefit, but expenses of burial and mourning are not allowed to be included in the compensation."

In Jackson *v.* Watson and Son, however, the rule established in Clark's case was limited to actions for wrongs and to actions brought under the Fatal Accidents Act, and the plaintiff was allowed damages for breach of a contract that certain tinned salmon was fit for human consumption, the damages including funeral expenses, medical expenses, and compensation for the loss of his wife, as the plaintiff had to pay a housekeeper to look after his seven children.

Alverstone, C.J., had said in Clark's case: "There has been no breach of duty towards the father and no property of the father has been injured," and the Court, in Jackson's case, held that here there had been a breach of warranty towards the husband as purchaser of the tinned salmon and that the property of the husband in the wife had been injured—that is, the husband had lost the services of his wife, and therefore her death and the funeral expenses consequent thereon were elements to be included in assessing the damages.

From the report of the case under review it does not appear clear whether the action was brought for a wrong—that is, in tort—or in contract. In tort, funeral expenses are clearly irrecoverable, but Jackson's case is authority for the statement that once a contractual duty is found to be owing from the defendant to the plaintiff (the husband), then in an action for its breach, funeral expenses and compensation for loss of his wife's services are recoverable.

Whether a doctor owes a contractual duty to a father for the breach of which funeral expenses resulting therefrom are recoverable has not yet been decided in the High Court. No legal argument as to the difference between an action for negligence and an action for breach of contract was addressed to the judge by either side in the Wandsworth County Court; no cases were cited, and the case therefore appears to be one in which appeal might lie to the High Court, since the law as it now stands in such cases in its relation to the medical profession is undefined. Farwell, L.J., in Jackson's case said: "I see no reason why a man who has an estate *pur autre vie* should not contract with, say, a doctor to maintain and attend and do his best to keep alive the '*vie*,' telling him of the value and importance thereof to him, nor why he should not recover damages founded on his actual loss if the '*vie*' died through the doctor's negligence." This is the only reference we have found to the possible position of a medical man in the judgements in the Court of Appeal.

Universities and Colleges.

UNIVERSITY OF OXFORD.

AT the Encaenia to be held on June 25th the honorary degree of Doctor of Science will be conferred upon Sir Humphry Rolleston, K.C.B., M.D.Cantab., President of the Royal College of Physicians of London.

UNIVERSITY OF LONDON.

AT the meeting of the Senate on May 21st Dr. R. A. Young was appointed to represent the University at the tenth annual conference of the National Association for the Prevention of Tuberculosis, to be held in London in July next.

The Graham Legacy Committee reported that Mr. Norman D. Ball (Hospital for Consumption, Brompton) had been appointed to the Graham scholarship (value £300) for a period of two years from April 29th, 1924, in succession to Mr. V. R. Khanolkar, who had resigned the scholarship, to which he was reappointed for two years from April 1st, 1923, on his acceptance of the post of Professor of Pathology in the Grant Medical College, Bombay.

UNIVERSITY OF BIRMINGHAM.

THE Council of the university has decided, on the recommendation of the Senate, to confer the honorary degree of LL.D. upon Sir Charles Sherrington, G.B.E., M.D. (President of the Royal Society), Sir John Bland-Sutton, LL.D. (President of the Royal College of Surgeons of England), Sir Arthur Keith, M.D., F.R.S. (Hunterian Professor at the Royal College of Surgeons of England), and Dr. F. Gowland Hopkins, F.R.S. (Sir William Dunn Professor of Biochemistry in the University of Cambridge). The degrees will be conferred at a special congregation on July 5th.

CONJOINT BOARD IN SCOTLAND.

THE following candidates having passed the requisite examination have been admitted diplomates in public health:

Marion B. Armstrong, D. Baird, G. Brewster, G. Buchanan, A. A. Charteris, A. C. Dewar, D. R. Hamilton, Agnes M. Hill, K. D. Mackintosh, Evelyn M'Pherson, G. Paterson, Bessie S. Ross, Eva M. Sturrock, J. G. Tait, Sarah B. H. Walker, Marion Watson, R. H. Williamson, Jessie M. L. Wright.

The following candidates passed Part I: D. G. Anderson, R. Armstrong, Janet R. Campbell, W. H. Carter, Isabella P. Crosbie, Elizabeth M'V. J. Currie, G. M. Currie, J. D. Dear, Agnes F. Dickson, W. Fraser, F. W. Gavin, Clara F. Gertzen, Jean M. Gilchrist, Christina Grant, A. Hamilton, W. A. Horne, T. M. Hunter, Jean V. Kirkwood, A. King, Annie G. Learmouth, J. C. Lindsay, Phyllis M. H. Lunn, Daisy B. M'Bride, Annabella M'Garrity, T. S. M'Kean, R. J. Matthews, Elizabeth P. Y. Paterson, A. Penman, G. H. Percival, W. C. Sharp, G. W. Simpson, C. C. I. Slorach, E. D. M. Wallace, Elizabeth Wheatley, A. B. Williamson, Anne C. Wilson, J. Yule.

The following candidates passed Part II: J. L. Connacher, Sheila Hunter, G. S. K. Iyer.

Obituary.

THE LATE PROFESSOR SHATTOCK.

DR. G. A. BUCKMASTER, Professor of Physiology in the University of Bristol, writes:

The tribute to the memory of Professor Shattock by Sir Charles Ballance, together with the concluding portions of the obituary notice in the BRITISH MEDICAL JOURNAL of May 17th, have indeed faithfully pictured him as he was to those who had the good fortune to possess his friendship. For myself this extended over more than thirty years. Shattock was endowed by Nature with a kind of continuous placid industry and a devotion to work for the work's sake, which during a long life stood out in sharp contrast to the impetuous, I might almost say fevered, output in science which is a feature of the present time. Quite clearly he recognized that there can be no such thing as a speeding up of research. Of his critical faculty I can recall many instances, and among these, his views on the remarkable tumour formation which may occur when the surface of the ovary is scraped in rabbits.

Though Shattock's name is unknown in connexion with what is called a great scientific discovery, all his work was pursued with a singleness of purpose and unsparing industry. He was a lover of scientific truth. One easily calls to memory some words with which Renan greeted Pasteur in 1882 on his reception into the French Academy. These may be fairly applied to others, indeed to anyone who possesses that uncompromising love of truth and honesty of purpose which was an outstanding feature of Shattock's mind. Reflecting on the industry of those who follow science as others follow art or literature, Renan said: "Truth, like a woman, is a great coquette. She will not be sought with too much passion, but often is most amenable to indifference; she escapes when apparently caught but gives herself up, if patiently waited for, revealing herself after farewells have been said."

To speak of Shattock as a surgical pathologist or as a microscopist, whatever these terms may mean, indicates a complete inability to understand his mind. Cohnheim is among the greatest of experimental pathologists, possibly the chief exponent of the application of physiological methods to the elucidation of pathological problems. It is his work and that of Virchow which profoundly affected Shattock's mode of thought. He was distinctively a pathologist who was wedded to experimental methods. Constantly devising experiments to clear up any problem on which he was engaged, he recognized with the clearest vision that physiology and pathology are so intimately related that they require identical methods of investigation.

It has been remarked that in many respects he resembled John Hunter, and the face in Reynolds's picture well shows the arresting, thoughtful expression into which Shattock not infrequently lapsed after a long talk. Faraday's greatness of achievement grows with time, and few can hope to approach this; but the perfectness of his scientific life has been equally displayed by others, and among these, though it is but a personal view, Shattock may be ranked. Devoid of scientific envy, of scientific jealousy or hate either in speech or thought, and giving freely of his time and knowledge to others, I still venture to think he was, though appreciated by many, understood by few. Incapable of the methods known to and practised by those who hunger for recognition, it may be questioned whether he really gained that position among his contemporaries to which he was entitled. But that he possessed the affection of his friends is incontestable.

However the words of a man may disguise him, his features seldom do so. Portraits in libraries or laboratories keep our memories awake. The record of a long life, devoted to work at the College of Surgeons and St. Thomas's Hospital Medical School, would be well perpetuated by a painting of Shattock as he was known in his later years.

Professor CHARLES JACOBS, founder of the Belgian Society of Gynaecology and Obstetrics and director of the Belgian Hospital in London during the war, has recently died.

The Services.

DEATHS IN THE SERVICES.

Colonel Charles Colhoun Little, Madras Medical Service (retired), died in a nursing home at Hove on April 21st. He was born at Raphoe, Letterkenny, on December 8th, 1848, the second son of the late Dr. Robert Little of Lifford, and after taking the L.R.C.S.I. in 1870, and the M.D. and M.Ch. of the Queen's University, Ireland, in 1871, entered the I.M.S. as assistant surgeon in 1872. He attained the rank of colonel on February 12th, 1900, and retired on February 12th, 1905. Almost his whole service was spent in administrative work. He took civil employment in 1877, and in July, 1881, he was appointed Inspector-General of Dispensaries, Superintendent of Vaccination, and Sanitary Commissioner of the Haidarabad Assigned Districts, otherwise known as the Berars, a very small province, which has since been absorbed into the Central Provinces. The duties were the same as those of an Inspector-General of Hospitals in one of the larger provinces, but the post carried no special rank. In June, 1897, he reverted to military duty as Principal Medical Officer of the Haidarabad Contingent; in October, 1899, he was appointed Inspector-General of Jails in Burma; and on promotion to administrative rank, in the following year, became Inspector-General of Civil Hospitals in that province. His son, the late Major G. C. C. Little, entered the I.M.S. in 1908, but was invalided for ill health on February 5th, 1920, and died at Midgham, Berks, on May 30th, 1921.

Lieut.-Colonel Richard Dawson Bennett, R.A.M.C.(ret.), died at Paignton on March 8th, aged 79. He was educated in Dublin, and, after taking the L.R.C.S.I. and the L.A.H. in 1858, entered the army as assistant surgeon in October, 1868. He attained the rank of lieutenant-colonel after twenty years' service, and retired in May, 1899. He served in the Ashanti war of 1873-74, was present at the actions at Dunquah and Abrakrampa, and received the medal.

Medical News.

THE Friday evening discourse at the Royal Institution on May 23rd was given by Dr. Andrew Balfour, director of the London School of Hygiene and Tropical Medicine, who by the courtesy of Colonel F. E. Russell, director of the International Health Board, showed a very remarkable kinematograph film compounded of one prepared by the Rockefeller Foundation and of another prepared in California. The film showed the life-history of the mosquito and the parasite, and brought home to the audience the antimalarial work undertaken in the United States and the brilliant results which have attended it. Dr. Balfour paid a compliment to the Americans as a people who united to their practical mind a certain idealism which often alone made success possible. In sketching the great ravages of malaria in the past he began with ancient Assyria, and suggested that an epidemic of this disease was responsible for the sudden destruction of Sennacherib's army. It had been suggested also that malaria was the secret of Greek decadence, and that the decline of Rome was due to the same cause. In the Middle Ages malaria was responsible for the extermination in the Roman Campagna of the finest army ever commanded by Barbarossa. The epidemic in the middle of the sixteenth century in England, and, in modern times, the failure of the French attempt to cut the Panama Canal were also described.

THE following courses have been arranged under the auspices of the Fellowship of Medicine and Post-Graduate Medical Association (1, Wimpole Street, W.1): A four weeks' course in gynaecology at the Chelsea Hospital for Women from June 2nd to 28th. From June 3rd to 27th eight clinical demonstrations on tropical diseases at the London School of Tropical Medicine. A course in urology from June 16th to July 12th at St. Peter's Hospital for Stone. At the Children's Clinic (Western General Dispensary) a course in children's diseases from June 16th to July 4th. A course in medicine and surgery from June 16th to 28th at the Royal Northern Hospital in conjunction with the Royal Chest Hospital. In July there will be special hospital courses in cardiology at the National Hospital for Diseases of the Heart, in ophthalmology at the Royal Eye Hospital, and a general course at the North-East London Post-Graduate College, Tottenham; in August a special course in diseases of the chest at the Brompton Hospital, and in neurology at the West End Hospital for Nervous Diseases.

THE mineral waters of St. Vincent, in the valley of Aosta, Italy, contain sodium sulphate, magnesium and sodium bicarbonate, and a considerable charge of carbon dioxide. The water therefore bears a great resemblance to the springs at Karlsbad. Dr. T. G. Garry has been appointed British physician to the springs at St. Vincent for the summer months.

THE house and library of the Royal Society of Medicine will be closed from Saturday, June 7th, to Monday, June 9th, both days inclusive.

THE Right Hon. Sir Auckland C. Geddes, G.C.M.G., K.C.B., M.D., has accepted the presidency of the Society for the Prevention of Venereal Disease, in succession to the late Lord Willoughby de Broke.

THE annual report of the Queen's Hospital for Children, Bethnal Green, appears this year unabridged, and contains a complete list of contributions received. The deficit of over £4,000 brought forward from 1922 has been increased during the past year, and a special appeal is being made for increased support. The average weekly cost of in-patients has been reduced from £3 12s. 11d. in 1922 to £3 9s. 10d. in 1923. During the past year the out-patients numbered 129,649, and 1,786 patients were admitted into the hospital.

THE National Baby Week Council announces that a series of awards will be offered by the *Daily News* to places which show the greatest reduction in the death rate of children between the ages of 1 and 5 during 1924, as compared with the average in the same places in the previous three years. Two awards of £25 and £10 respectively are open in each case to large towns of 50,000 population and upwards, districts between 20,000 and 50,000, and smaller districts between 5,000 and 20,000. The adjudication will be undertaken by the National Baby Week Council, and the awards made upon the corrected figures furnished by the local medical officer of health.

As briefly recorded last week, a medical missions meeting was held during the S.P.G. anniversary week in the Church House on May 14th. The chair was taken by Sir Humphry Rolleston, K.C.B., President of the Royal College of Physicians, who said that the care of the soul and the care of physical ills had been closely allied since the time of Hippocrates. With the advent of true religion and the development of medicine they became separated, but in medical missions they were combined and worked together to their mutual advantage. He wished whole-heartedly to express admiration for the noble members of our profession devoting themselves soul and body to medical missions. Banished from those they loved, without the comforts and material advantages of their home, they followed the example of the Beloved Physician, St. Luke, scorning ambition and all selfish aims. Miss Dora Tickell, a member of the delegation sent to India by the society, spoke of the present-day changing conditions in that country. Mission hospitals had gained the confidence of the people to an extraordinary extent. Further, they had a great work to do in the training of Indian nurses and women doctors. She suggested that in every mission area there should be a number of small dispensaries with Indian men and women doctors in charge, linked up with a hospital under the care of a highly qualified doctor, European or Indian. Such a policy would demand large reinforcements of personnel and money. Miss Grace Crosby paid a tribute to the medical missionaries and to the Chinese doctors and nurses whom they are training and sending out to help their own countrypeople. Dr. H. H. Weir pointed out that even if all the existing posts were filled at once that would hardly touch the fringe of the need for more doctors.

THE annual general meeting of the Lebanon Mental Hospital, Beyrout, Syria, will be held at Caxton Hall, Westminster, on Tuesday, June 3rd, at 5 p.m., with Dr. E. W. G. Masterman in the chair.

A MEETING of the Scottish Western Association of the Medical Women's Federation will be held in Queen Margaret College, Glasgow, on Tuesday, June 3rd, when Drs. Madeline Archibald and Chapman will open a discussion on the notification of venereal disease. All medical women in the Glasgow area, whether members of the Federation or not, are cordially invited to attend.

A NEW Italian university has recently been established at Milan. The first rector is Professor Luigi Mangiagalli, a well known gynaecologist.

THE Nordhoff-Jung prize for the best work on cancer published during the last few years has been awarded to Professor Fibiger of Copenhagen for his experimental reproduction of cancer by *Spiroptera*.

THE fourth congress of the International Union against Tuberculosis will be held at Lausanne from August 5th to 7th, and will be followed by an eight days' excursion to the principal antituberculosis stations in Switzerland, including Leysin, Montana, Berne, Zürich, Davos, and Arosa. The principal questions to be discussed are as follows: (1) Do there exist in nature or is it possible to create saprophytic forms of the tubercle bacillus which are capable of being transformed into virulent bacilli? introduced by Professor Calmette of Paris; (2) Relations between pregnancy and tuberculosis, introduced by Professor Forssner of Stockholm; (3) Effect of antituberculosis organizations in various countries on the mortality from tuberculosis, introduced by Sir Robert Philip of Edinburgh; (4) Prophylaxis of tuberculosis in the child, introduced by Professor Léon Bernard of Paris. Further information can be obtained from the secretary, Via Toscana 12, Rome.

THE Rockefeller Foundation is supplying Germany with six copies each of four hundred British and American medical periodicals. Two copies will be kept in the libraries of Berlin and Munich, while the other four will be circulated throughout the various German universities, which will be divided for this purpose into four groups.

MESSRS. JOHN BALE, SONS, AND DANIELSSON will shortly publish the first number of the *Franco-British Medical Review*, which has been planned to encourage and advance the medical *entente cordiale* between the two nations. It will contain an equal number of English and French articles, the latter being translated into English, while the English articles will afterwards be translated into French and be published in French journals.

THE second Congress of Polish Pediatrists will be held at Poznàu from June 23rd to 25th, when the subjects to be discussed are the treatment of congenital syphilis, introduced by Dr. Groer of Lwow; recent discoveries relating to immunity in children, introduced by Dr. Brokman of Warsaw; and the scientific bases of social hygiene in childhood, introduced by Dr. Szenajch of Warsaw.

THE number of deaths from plague in Java was 942 in November, 1,054 in December, and 967 in January.

Letters, Notes, and Answers.

Communications intended for the current issue should be posted so as to arrive by the first post on Monday or at latest be received not later than Tuesday morning.

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

ORIGINAL ARTICLES and LETTERS *forwarded for publication are understood to be offered to the* BRITISH MEDICAL JOURNAL *alone unless the contrary be stated.* Authors desiring reprints of their articles published in the BRITISH MEDICAL JOURNAL are requested to communicate with the Financial Secretary and Business Manager, 429, Strand, W.C.2, on receipt of proof.

ALL communications with reference to advertisements as well as orders for copies of the JOURNAL should be addressed to the Financial Secretary and Business Manager, 429, Strand, London, W.C. Attention to this request will avoid delay. Communications with reference to editorial business should be addressed to the Editor, BRITISH MEDICAL JOURNAL, 429, Strand, W.C.2.

THE telephone number of the BRITISH MEDICAL ASSOCIATION and BRITISH MEDICAL JOURNAL is Gerrard 2630 (Internal Exchange). The telegraphic addresses are:

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The address of the Irish Office of the British Medical Association is 16, South Frederick Street, Dublin (telegrams: *Bacillus, Dublin*; telephone 4737, Dublin), and of the Scottish Office, 6 Rutland Square, Edinburgh (telegrams: *Associate, Edinburgh*; telephone, 4361, Central).

QUERIES AND ANSWERS.

DYSPNOEA ASSOCIATED WITH GASTRO-INTESTINAL DERANGEMENT IN CONGENITAL HEART DISEASE.

"J." has under treatment a female child, aged 10 months, who suffers from congenital heart lesion. The bowels tend to be constipated: the motions are bright yellow and of clayey consistence, with occasional small curds and very occasionally a little mucus: the smell is sour, but not definitely putrid. Attacks of pain, first noticed at the age of 4 months, are now occurring about every second day. They are short and are followed by great expiratory dyspnoea with slight cyanosis, which lasts for six to twelve hours: great exhaustion follows these attacks, which might be either of anginal or intestinal origin, and which are usually but not invariably connected with the acts of defaecation. "J." would be grateful to any reader for advice on how to render these attacks less frequent, either by dietetic or medicinal means, and on how to abort or lessen the severity of the subsequent dyspnoea.

SUNLIGHT FOR CHRONIC ECZEMA.

DR. R. KAY NISBET (Hindley) writes: I have a case of a boy, 5 years of age, who has a dry scaly eczema covering his body with the exception of the exposed parts—that is, hands, face, and legs. As his condition is so definite in its situation it occurred to me that the clothing aggravated the condition, and I should like to know if there is any colony in England where he could be allowed to go about nude?