parotid, submaxillary, and lacrymal glands. The enlargement of these latter had apparently been much greater a few weeks prior to coming under our observation, and had no doubt given rise to the erroneous conclusion that the patient was suffering from kidney trouble. The swellings were smooth, uniform, and not fixed. It was thought that the accessory lacrymal glands were palpable, but not the socia parotidis. The glands of Blandin-Nuhn were distinctly felt as two round hard swellings at the tip of the tongue, as described by Ziegler.[1] The sublingual glands did not seem to be abnormal and the swellings sometimes said to be found on the hard palate were not observed. The liver and spleen were not enlarged; there were lymphatic glands palpable in the neck near the submaxillary glands, but otherwise the lymphatics did not appear to be affected. The tonsils had been removed some years previously. A blood count showed 5,600,000 red cells, haemoglobin 90 per cent., leucocytes 10,000. A differential count showed 62.5 per cent. polymorphonuclear leucocytes, 6.5 per cent. hyalines, and 31 per cent. lymphocytes. The urine was normal.

Since the syndrome of simple lymphomatous hyperplasia of lacrymal and salivary glands was first described by Mikulicz, many cases resembling but not synonymous with this condition have been recorded from time to time in the literature. Von Brunn has attempted to classify the various diseases associated with these symptoms as follows:

1. *Cases without alteration in the blood—*
   (*a*) Without symmetrical swellings of the spleen or lymphatic glands.
   (*b*) With swellings of the spleen or lymphatic glands.
2. *Cases with alteration in the blood—*
   (*a*) Severe aplastic anaemia with lymphatic pseudo-leukaemia.
   (*b*) Leukaemia.

Only cases coming under Group 1 (*a*) appear to be true cases of Mikulicz's disease. Campbell Howard collected 55 cases of this type down to 1909, but since then few, if any, cases have been recorded in the literature. The most recent contribution on the subject which we can find appears to be that of Thursfield in 1914,[2] and his case appears to have been one of "lymphatic pseudo-leukaemia." Our case certainly comes under Group 1, and, except for two doubtful glands in the neck, the lymphatic apparatus does not appear to have been involved.

The association of our case with a tuberculous condition of the chest is interesting, for whilst the majority of cases appear to be a simple chronic interstitial inflammation, non-tuberculous (Igersheimer and Pollot),[3] both tuberculous (Krailsheimer, Pitt, and Napp)[3] and syphilitic cases (Lange, Luders, Gutmen, and Jackobaus)[3] have been recorded from time to time.

PROGNOSIS AND TREATMENT.

According to Thursfield,[2] prognosis is bad in the leukaemic and pseudo-leukaemic, but appears to be good in true cases of Mikulicz's disease. Arsenic and potassium iodide are usually recommended in treatment. The results of operative intervention appear to have met with different results in the hands of different observers. Ziegler records how removal of one of the enlarged glands has resulted in great increase in the size of the rest. Elliot, on the other hand (*Ophthalmoscope*, 1911),[3] has recorded a case in a Hindu woman in which operation on the lacrymal glands was successful and was followed by diminution in the size of the parotids and submaxillaries. In view of the uncertain results of the cases recorded we have not thought operation justifiable in our case, especially as the swellings are giving rise to no unpleasant symptoms; we are simply giving arsenic and potassium iodide. *X* rays have met with success in some cases.

In regard to the remarkable chest condition revealed by the skiagram such cases have been recorded before. H. K. Dunham and J. H. Skavlem[4] say:

"Many cases of healed miliary tuberculosis are being found by our more general use of the *x*-ray chest studies. This diagnosis is only justified when the subject gives no history of work in a dusty trade. Lungs of anthracite miners most nearly simulate miliary tuberculosis. The *x*-ray picture is that of fine, sharp, discrete studdings, more or less evenly distributed throughout all lobes. . . . Most peculiarly these patients seldom, if ever, give any history suggesting serious lung infection."

The undiagnosed illness with which the patient was affected at the age of 2 is not without interest, however, although its significance is difficult to estimate. Opie[5] has noted in several necropsies extensive calcified tubercles of the lung and lymph nodes, so that "a grave infection must have existed at some time previous—even though there had been no history of corresponding symptoms, there was doubtless at some period imminent danger of death from tuberculosis."

Prognosis is necessarily uncertain from lack of experience of similar cases. Dunham[4] considers that such patients are likely to go downhill rapidly if they become subsequently infected.

We are indebted to Dr. Clive Riviere for permission to publish this case; to Dr. Sparks, who took the *x*-ray film; and to Dr. D. S. Page, who did the blood count.

REFERENCES.

[1] Ziegler, S. L. (1909): *New York Med. Journ.*, December, 1911. [2] Thursfield, H.: *Quart. Journ. of Med.*, April, 1914. [3] Quoted from Thursfield, loc. cit. [4] Dunham H. K., and Skavlem, J. H.: *Tubercle*, February, 1924. [5] Opie, E. L.: *American Review of Tuberculosis*, 1922, 5, 7.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

HERPES ZOSTER AND VARICELLA.

As the relationship of herpes zoster and chicken-pox is still undecided, I desire to place the following case on record.

On December 19th, 1924, a woman developed herpes zoster. On January 3rd, 1925, her son, aged 5 years, was covered with a typical rash of chicken-pox. The following facts seem to point to some relationship between the two diseases:

1. The boy had not been away from his own home for several weeks.
2. There is not a case of chicken-pox in his neighbourhood, so far as I can ascertain.
3. The child slept in a cot in his mother's room.
4. The fourteen days' interval between the onset of the two diseases agrees with the incubation period of chicken-pox.

On the other hand, if there is any relation between herpes zoster and chicken-pox, it is strange that the coincidence of the two diseases should be so infrequent. This is the first occasion that I have seen them occur in the same family at the same time.

Northwood, Middlesex. D. D. RITCHIE, M.A., M.D.

RUPTURE OF ABDOMINAL WALL WITH PROTRUSION OF UNINJURED INTESTINE.

THE interest of the following case appears to me to lie in the fact that a crushing injury of the abdomen could produce a rupture of the abdominal wall and protrusion of the intestines without injury to the intestines or other viscera, as is usually found.

A boy, aged 16, was admitted to hospital on October 3rd, 1924. He had been crushed between the buffers of two railway wagons, and it was found on examination that about three feet of small intestine protuded through an opening below the tenth rib in the mid-axillary line.

The patient was anaesthetized and several small lacerated wounds were found in the skin, through one of which the intestine was protruding. On incising the skin there was a gap, four inches in length horizontally and two inches wide, in the muscular layers and peritoneum of the abdominal wall, with great laceration of the tissues. The intestine appeared to have escaped injury, and was replaced within the abdomen. The eleventh and twelfth ribs were fractured and the distal portions of these were removed. After excising all damaged tissues the layers of the abdominal wall were brought together with difficulty and closed. A laparotomy through a left paramedian incision was then performed to exclude injury to abdominal viscera, but nothing abnormal was discovered except some retroperitoneal haemorrhage, not extensive.

The boy made an uninterrupted recovery and his abdominal wall is now perfectly sound with no bulging at the site of the injury.

R. W. P. HOSFORD, M.B., B.S., F.R.C.S.,
Resident Surgical Officer, Wolverhampton and Staffordshire Hospital.

MYELOID LEUKAEMIA ENDING AS LYMPHATIC LEUKAEMIA.

THE case reported below is interesting because of the remarkable reduction of the myeloid leucocytes from 892,000 to 11,600, with corresponding recovery of health, so that the man was able to return to work. It was very disappointing that acute lymphatic leukaemia should have supervened, as it is not primarily a disease of the bone marrow like the myeloid condition. This case is not a solitary coincidence, since, a few years ago, another patient with myeloid leukaemia, whom I had successfully treated with *x* rays, also died of lymphatic leukaemia.

A man, aged 38, was admitted to hospital under me in February, 1923, with an enormous spleen extending into the left iliac fossa. His blood count was: red cells 2,820,000, leucocytes 892,000 (polymorphs 44 per cent., lymphocytes 16 per cent., eosinophils 4 per cent., mast cells 4 per cent., myelocytes 32 per cent.). There were several small retinal haemorrhages, and, soon after admission, he developed a large haematoma beneath the left scapula. This became so painful that 12 oz. of altered blood were aspirated from it; it filled up again, however, but with less pain. It was slowly absorbed, lasting in all about three months. The treatment employed was exposure to *x* rays twice weekly of the heads of the long bones at the knees, hips, and shoulders, and of the spleen, the dosage being arranged by Dr. W. B. Prowse. The leucocytes steadily diminished in number, rather more rapidly when arsenic was given as well as the *x*-ray treatment. The man's condition also improved and his spleen became much smaller.

In February, 1924, his blood count was: red cells 4,030,000, leucocytes 56,100 (polymorphs 73 per cent., lymphocytes 2 per cent., eosinophils 2 per cent., mast cells 7 per cent., myelocytes 16 per cent.), and he was able to do light work. In July he was strong and well, and the spleen was only an inch below the costal margin. The blood count then was: red cells 4,856,000, leucocytes 11,600 (polymorphs 76 per cent., lymphocytes 5 per cent., mast cells 11 per cent., myelocytes 1 per cent.), and the *x*-ray treatment was suspended. At the beginning of September he became rapidly short of breath and very anaemic. His blood count was then found to be: red cells 2,760,000, leucocytes 160,000 (lymphocytes 94 per cent., polymorphs 4 per cent., and myelocytes 2 per cent.). He died of this acute lymphatic leukaemia in three weeks.

WALTER BROADBENT, M.D., F.R.C.P.,
Physician to the Royal Sussex County Hospital.

GASTRIC CANCER TREATED BY PYLORECTOMY AND GASTRO-ENTEROSTOMY.

THE case here recorded is of interest on account of the following peculiar characteristics: (1) the very unusual amount of peristalsis definitely ending in the tumour; (2) the extensive mobility of the growth; and (3) the absence of glands, adhesions, or ulceration, yet almost total occlusion of pylorus.

A. T., a lady aged 72, consulted us in December, 1924, complaining of obstinate vomiting; food was rejected immediately after being taken. No history of haematemesis was given. She had constant epigastric pain, and had lost a considerable amount of weight. The symptoms were of three months' duration. Examination of the abdomen revealed marked peristalsis, the waves showing a rise of one inch above the surrounding abdominal wall. A definite tumour, the size of a hen's egg, was palpable under the right rectus. It was firm and freely movable in all directions. Splashing was distinctly audible on palpating the stomach, and the peristaltic waves could be felt to end at the tumour. There was no free fluid in the abdomen, no glands were palpable, and there was no enlargement of the liver.

Operation.—A right rectus incision was made, and the muscle retracted outwards. The tumour was found to be the pylorus; it could be easily lifted out of the abdomen. There was no evidence of adhesions or glandular involvement. The liver was normal. The stomach was much enlarged and thickened. Posterior gastro-enterostomy was first performed, as it was doubtful how the patient would stand resection, but when it was found that her condition was favourable we proceeded to remove the pylorus, one inch of the first part of the duodenum, and as much of the pyloric end of the stomach as possible.

Recovery was uneventful, and when she left the nursing home nineteen days later she was able to eat full diet with no discomfort.

Examination of the specimen showed that the mucous membrane was intact over the tumour area; there were no signs of previous ulceration. The pyloric canal was almost completely occluded. The carcinoma presented colloid degeneration.

C. L. GRANVILLE CHAPMAN, F.R.C.S.Ire.,
Surgeon, Grimsby and District Hospital.
S. E. DUFF, M.B.Belf., F.R.C.S.Ed.,
Surgeon, Grimsby and District Hospital.

Reports of Societies.

POST-OPERATIVE PULMONARY AFFECTIONS.

A COMBINED meeting of the Sections of Surgery, Anaesthetics, Medicine, Obstetrics and Gynaecology, and Pathology of the Royal Society of Medicine was held on February 4th to discuss "The prevention and treatment of post-operative pulmonary affections." Mr. H. J. PATERSON was in the chair.

Mr. E. C. LINDSAY said that there was a growing belief that post-operative lung complications, such as pneumonia, pleurisy, and collapse, which had been a source of contention and mutual reproach between surgeon and anaesthetist, were not the result of irritation or congestion, but were in fact the result of pulmonary embolism and infarction. Wharton and Pierson considered that 40 per cent. of pleurisies and 12 per cent. of pneumonias after gynaecological operations were due to pulmonary embolism. Such embolism might be of (1) the massive type, occluding one or both pulmonary arteries; (2) the infarction type, followed by pleurisy and signs of consolidation; (3) the type where the site of the embolus prevented its recognition as such; this type was associated with slight respiratory increase, mild evening pyrexia, and the expectoration of small quantities of blood and mucus. Two cases were quoted in which this third type of embolism had served as a warning—in one case of the massive embolism that occurred later, and in the second case of thrombosis of the veins of the leg. It was noteworthy that in many cases a premonitory sign of the massive type of embolism was an urgent desire to defaecate, and the speaker suggested that this might be due to a vaso-motor reflex set up by the passage of the clot from the femoral or iliac veins. Sir Charles Gordon-Watson and Wharton and Pierson had emphasized the importance of the slight evening rise of temperature as a constant premonitory sign. A research into the records of surgical cases at the London Hospital for the years 1914-24 revealed 114 undoubted cases of pulmonary embolism. It had been stated that this unfortunate condition was increasing, and changes in blood character and coagulability depending on changes of diet had been suggested as a cause. But in Mr. Lindsay's opinion the increase was more apparent than real, since the percentage in the London Hospital cases agreed very closely with Rupp's figures as the result of the investigation of over 22,000 operations from 1903 to 1920. Rupp also found that the mortality of pulmonary embolism in internal disease without operation was 1.1 per cent.—four times as high as that following operation. An analysis of the London Hospital cases showed that age was a very important factor, the average for the series being 52 years. The average of urinary bladder and prostate operations complicated by pulmonary embolism worked out at 60 years, and even in appendicitis the average age was 30.4 years, although there were included among them cases whose ages were 2½, 11, and 13 years. As regards the different types of operations which were responsible for embolism, 21 cases occurred in 2,778 gastric operations, 22 cases in 2,004 major gynaecological operations, 17 cases in approximately 4,000 appendix operations, and 12 cases in 1,967 hernia operations. As in other published series, gynaecological operations therefore headed the list in order of frequency. *Post-mortem* examination revealed thrombosis in 42 per cent. of the cases, the thrombosis being in the left common iliac or left iliac vein in half of these cases. Thrombosis of the pelvic, iliac, and femoral veins was found in 47 per cent. of the gynaecological cases, and 57 per cent. of the gastric cases. This was remarkable, since in one case the operation involved the systemic venous system and in the other the portal system. In none of the *post-mortem* notes was there any mention of extensive thrombosis at the site of operation. The question of primary pulmonary thrombosis had been discussed by Professor Glynn and others, but the speaker found it difficult to reconcile the size of the thrombus, its considerable length, its frequently unbranched appearance, and the fact of its being nearly always rolled up, with the formation of the clot in the

included Sir Charles Sherrington, G.B.E., M.D. (President of the Royal Society), Sir W. Arbuthnot Lane, Bt., Sir James Purves-Stewart, Sir Thomas Parkinson, and Dr. Percy Kidd. Professor David Waterston and Mr. John Adamson represented the St. Andrews Institute for Clinical Research. The British Medical Association and its Burnley Division were represented by the Deputy Medical Secretary, Dr. G. C. Anderson; the BRITISH MEDICAL JOURNAL by the Assistant Editor, Dr. N. G. Horner. After the cremation the ashes were placed in an urn and deposited in the columbarium at Golders Green.

We regret to announce the death of Dr. WILLIAM MANSON FERGUSSON, on January 24th, at the age of 41. Some weeks ago he and his whole household, including his professional assistant, were attacked by typhoid fever. Dr. Fergusson's attack was very severe and attended by complications. He was removed to a nursing home in Aberdeen, where he died. Dr. Fergusson was born in Banff and educated at Banff Academy, Aberdeen, Dublin, and London. He graduated M.B., Ch.B.Aberd. in 1905, obtained the diploma L.M. in 1906, and proceeded M.D. in 1911. His appointments included those of clinical assistant to the Hospital for Women in Soho Square, and junior assistant to the Royal London Ophthalmic Hospital. In 1906 he joined his father in medical practice in Banff. Since 1912 he had been surgeon to Chalmers Hospital, Banff, after six years' preliminary work as assistant surgeon, and took a leading part in the development of that institution. He was assistant visiting surgeon to Banff District Asylum, and lecturer and examiner to the British Red Cross Society. In 1907 he received a commission as surgeon lieutenant in the 1st Banff Royal Garrison Artillery, and in August, 1914, he was mobilized as captain in the R.A.M.C.(T.F.). Although invalided out in 1915, he rejoined with the rank of captain in 1918. After being medical officer in charge of the auxiliary hospital at Banff, he served in France in 1918. He was chairman this year of the Banff, Elgin, and Nairn Division of the British Medical Association. He published several papers on gynaecology and surgery in the BRITISH MEDICAL JOURNAL, and in the *Journal of Obstetrics and Gynaecology of the British Empire* an article on the history, technique, uses, and dangers of ventrofixation. The high esteem in which Dr. Fergusson was held as the result of his outstanding ability as a surgeon was shown by the large number who attended his funeral on January 27th. The British Medical Association was represented by the Divisional Secretary, Dr. G. S. Sowden, and Drs. R. Douglas and S. C. Ironside, members of the Divisional Executive Committee. He leaves a widow, to whom, on behalf of the profession, we tender sincere sympathy.

Dr. JOHN DEWAR of Hampstead, who was knocked down and killed by a motor car on January 31st while on his way to visit a patient, was the chief of the Clan Dewar. He was born at Perth in 1844, and was educated at Anderson College and Glasgow University. In 1866 he obtained the diplomas L.R.C.P., L.R.C.S.Edin., and L.M., and shortly afterwards entered into partnership with Dr. J. P. Scatliff, whose daughter he married in 1874. For over thirty years Dr. Dewar practised in Sloane Street, London, and subsequently at Hampstead. He was formerly senior surgeon to the Hospital for Women and Children in Vincent Square, and surgeon for diseases of women and children to the Chelsea, Brompton, and Belgravia Dispensary. He was the editor for some time of the *Nursing News and Hospital Review*, and the author of several small popular works on diet and infant management. He contributed articles on gynaecology to the BRITISH MEDICAL JOURNAL and other periodicals. Dr. Dewar was a strong Presbyterian and had held office as an elder for many years. He was a member of the British Medical Association. He leaves a widow, a daughter, and four sons, one of whom is practising medicine.

Dr. BANTI, professor of morbid anatomy in the University of Florence, who had given his name to a form of splenic anaemia, has recently died.

Universities and Colleges.

UNIVERSITY OF LONDON.

UNIVERSITY COLLEGE.

THE introductory medical course for students who have matriculated in the University of London will begin at University College on Monday, March 2nd. Intending students should apply at once, and should attend at the College on Monday, March 2nd, at 11 a.m.

NATIONAL UNIVERSITY OF IRELAND.

ON Saturday, February 7th, the following degrees in the Faculty of Medicine were conferred in the hall of University College, Dublin:

M.B., B.Ch., B.A.O.—T. D. Donegan, G. A. Busby, B. J. Carlin, Jane Carraher, Mary Courtney, R. J. Cullen, V. P. Donohoe, Hilda M. Doyle, M. Finn, A. C. Francis, J. Griffin, C. Hannigan, M. J. Harte, L. A. Hayes, T. Hill, C. E. Hurley, B.A., J. Kennedy, B.A., J. B. Lynch, Mary M'Givern, Josephine M'Govern, P. E. M'Kernan, M. P. M'Manus, M. MacSweeney, Violet B. Madden, J. S. Mahony, J. G. Molony, M. P. Moriarty, T. Murphy, Margaret M. Nolan, B.A., A. O'Donovan, M. A. O'Dwyer, Margaret O'Farrell, J. P. O'Kane, J. J. A. O'Leary, D. J. O'Regan, E. O'Reilly, D. Rafferty, Ita Ryan, J. Sexton, Jerh. Twohill, J. Walsh.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND.

AT the monthly meeting of the President and Fellows, held on Friday, February 6th, the following candidates, having duly passed the required examination, were admitted as Licentiates in Medicine and Members of the College: Cyril James Ussher Murphy, M.B., B.Ch., B.A.O.Dubl.; M.D.; William Thomas Noonan, M.B.Toronto.

At a special meeting held on Saturday, February 7th, Sir Humphry Rolleston, Bt., K.C.B., President of the Royal College of Physicians of London, was the recipient of the Honorary Fellowship of the College. After the ceremony of conferring the honorary fellowship, Sir Humphry delivered an address on "Individual links between the Royal Colleges of Physicians of London and Dublin" (see page 327).

Medical News.

IT will be remembered that on two previous occasions parties of medical men from other countries have visited Great Britain to study British public health services. A third party, now in this country, was received on February 8th by the Society of Medical Officers of Health, addresses of welcome being given by Professor Kenwood and Colonel S. P. James, of the Ministry of Health. On February 9th the party was received by Mr. Neville Chamberlain at the Ministry of Health, when an address was given by Sir George Newman on English public health administration. Later in the day the company divided into three groups, one going to Wolverhampton and district, another Leeds and the West Riding, and the third Willesden and Middlesex. The party will leave this country on March 24th for the closing conference at Geneva. The visits are arranged by the Health Organization of the League of Nations, with the financial assistance of the Rockefeller Foundation. Similar visits have been paid in other years to Italy, Belgium, Austria, Holland, Denmark, Switzerland, and the United States.

DR. J. R. KAYE, the County Medical Officer for the West Riding of Yorkshire, has been elected President of the Association of County Medical Officers of Health for England and Wales.

A CHADWICK public lecture on international hygiene will be delivered by Dr. E. W. Hope at the Medical Society of London, 11, Chandos Street, Cavendish Square, on Monday, February 16th, at 5.15 p.m., with Sir James Crichton-Browne, M.D., F.R.S., in the chair. On Monday, March 9th, at 8 p.m., in the Inner Temple Hall, Lord Newton will give an address on the necessity for legislation with regard to smoke abatement, with Sir William J. Collins, K.C.V.O., M.D., in the chair. In May Professor Brumpt, of the faculty of medicine in the University of Paris, will give two lectures (in English): (1) how to conduct an antimalarial campaign, and (2) the prophylaxis of sleeping sickness. On June 11th, at 5 p.m., in the Chelsea Physic Garden, Sir Daniel Hall, K.C.B., F.R.S., will discourse on the sources of the fruit and vegetable supply of London. Admission to all Chadwick public lectures is free.

DR. ROWLAND L. THOMAS of Whitland has been appointed coroner for West Carmarthenshire.

THE annual county medical dinner organized by the West Riding Local Medical and Panel Committee will be held at the Hotel Metropole, Leeds, on Tuesday, March 31st, at 6.30 for 7 p.m., when the chair will be taken by Sir Berkeley Moynihan, Bt. Tickets 12s. 6d. (exclusive of wine), to be obtained from Dr. W. Eardley, 50, Burlington Crescent, Goole,

A LECTURE on modern atmospheric conditions will be given before the Royal Society of Arts on Wednesday next, February 18th, at 8 p.m., by J. S. Owens, M.D., A.M.Inst.C.E., superintendent, Advisory Committee on Atmospheric Pollution, Air Ministry. Dr. Owens has written on the rate of settlement of solids in water as well as on atmospheric pollution.

THE Fellowship of Medicine announces that on February 20th Sir James Dundas-Grant will lecture on some points in the diagnosis and treatment of tuberculosis and cancer of the larynx, at the Royal Society of Medicine, at 5.30 p.m. Beginning on February 16th, a fortnight's course in medicine, surgery, and the special departments will be held at the Prince of Wales's Hospital, Tottenham. In the mornings there will be demonstrations of modern clinical methods; in the afternoons demonstrations of groups of selected cases and clinics in the various hospital departments; and at 4.30 p.m. each day there will be a special clinical lecture. The opening lecture of the course will be given by Mr. James Sherren on appendicitis. On March 2nd a three weeks' course in medicine, surgery, and gynaecology will commence at the Royal Waterloo Hospital, and include heart disease and diseases of the nervous system, the blood, and the breast. A four weeks' afternoon course in ophthalmology will begin on March 9th at the Central London Ophthalmic Hospital; an operative surgery class will be held by arrangement for an additional fee. The Chelsea Hospital for Women is arranging a special three weeks' course from March 16th. At the Hospital for Diseases of the Chest (Brompton) a fortnight's course begins on March 16th. The Royal Northern Hospital, in conjunction with the Royal Chest Hospital, is arranging an intensive course in medicine, surgery, and the special departments from March 23rd to April 4th. Copies of the syllabuses of these courses may be obtained from the Secretary of the Fellowship at No. 1, Wimpole Street, W.1.

IRISH newspapers announce that Dr. T. Hennessy, Irish Medical Secretary of the British Medical Association, has accepted the invitation of the Government of the Free State to become a candidate for election to the Dail for South Dublin City.

ON and after April 1st next grants made to health visitors will be paid by the Minister of Health instead of the Board of Education. The circular letter in which this change is announced states that on and after April 1st, 1928, the appointment of a woman for the first time to be a health visitor will not be approved unless she has obtained a certificate granted by a central examining body approved by the Minister.

AT the meeting of the Nottingham Mental Dispensary Committee, held on January 28th, the town clerk reported that the Board of Control had approved the purchase of Aston Hall and park, comprising 88 acres, and about 56½ acres of adjoining land to be used as a home for mental defectives. The institution will, it is hoped, provide accommodation for 400 beds and a resident staff.

AT the meeting of the West Kent Medico-Chirurgical Society at the Miller General Hospital, Greenwich, to-day (Friday, February 13th), at 8.45 p.m., Dr. Harold Pritchard will read a paper on some modern aspects of disease.

THE nave of Epsom College War Memorial Chapel will be consecrated by the Bishop of Winchester (visitor of the College) on Saturday, February 21st, at 3 o'clock. Contributors to the war memorial fund who wish to be present at the ceremony should apply for a card of admission to the Bursar, Major Walter L. Giffard, the College, Epsom, Surrey.

MESSRS. MANN, EGERTON AND CO., LTD., have made for Daimler Hire Limited a very luxurious ambulance body for a 45-h.p. Daimler chassis. Special attention has been given to ease of loading and the comfort of the patient's bed, and for his removal from his room folding carriers are provided. Two chairs are fixed for attendants. In addition to lockers there is a wash basin with water supply. Attention has been given to the ventilation and lighting of the body. One aim the makers kept in view is that the ambulance when travelling shall resemble an enclosed limousine.

THE twentieth International Congress of Anatomy will be held at Turin from April 6th to 8th under the presidency of Professor G. Romiti. Titles of papers should be sent to Professor G. Levi, Istituto Anatomico, Corso M. d'Azeglio 52, Turin.

AT the meeting of the Medico-Legal Society to be held at 11, Chandos Street, W.1, on Tuesday next, February 17th, at 8.30 p.m., Dr. Godfrey Carter will read a paper on the psychology of the criminal, which will be followed by a discussion.

WE hope to publish next week a memoir of Dr. E. E. Klein, F.R.S., the eminent bacteriologist and histologist, whose death at the age of 80 is announced as we are going to press.

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.* 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.

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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.

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

EDITOR of the BRITISH MEDICAL JOURNAL, *Aitiology Westrand, London.*

FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Articulate Westrand, London.*

MEDICAL SECRETARY, *Mediocera Westrand, London.*

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.

SNORING.

"WILTSHIRE" writes: Can any reader of the BRITISH MEDICAL JOURNAL kindly advise how to prevent snoring in adult life? The patient, a man aged 50, healthy, has no nasal obstruction, is not a mouth-breather, and only recently acquired this habit.

HOUSE DUTY.

"T. D. H." writes: I pay £100 a year rent for my house; I am allowed £50 by the Inland Revenue, but I have to pay house duty on the £100. Is that right?

*** Yes, it is correct, though the reference is presumably to the house duty chargeable for 1923-24 and prior years, as it has been abolished as for 1924-25 and onwards. The point is that whereas house duty—and income tax under Schedule A—is, like local rates, chargeable on the premises as a whole, the amount of rent to be allowed as representing a professional expense is determined by the portion of the premises used for professional purposes.

LETTERS, NOTES, ETC.

THE INACCURATE ANTIS.

DR. W. D. O'KELLY (Department of Pathology and Bacteriology, University College, Dublin) writes: My attention has been drawn to an article in the *Vaccination Inquirer* of February 2nd by the receipt through the post (anonymously from London) of a marked copy of this publication. The article in question refers to a discussion on the value of the Schick test at a recent meeting of the Section of Pathology of the Royal Academy of Medicine in Ireland. I write to say that the account of my remarks given in the article in question is inaccurate and misleading.

INFLUENZA.

SURGEON COMMANDER LLEWELLYN LINDOP, R.N., writes to suggest that in influenza the point of infection is the eye, and that the cough-spray, reaching the conjunctival sac, incubates there and infects the nose by way of the lacrymal duct. He thinks, further, that infection of the respiratory tract is by contiguity of tissue, and that the risk of infection would be diminished if persons travelling in trams, buses, and tubes, in reach of infected coughers, could be persuaded to wear well fitting motor goggles. An ordinary pair of horn spectacles would, he says, be better than nothing, but would not cut off lateral splash.

VACANCIES.

NOTIFICATIONS of offices vacant in universities, medical colleges, and of vacant resident and other appointments at hospitals, will be found at pages 34, 35, 36, 37, 40, and 41 of our advertisement columns, and advertisements as to partnerships, assistantships, and locumtenencies at pages 38 and 39.

A short summary of vacant posts notified in the advertisement columns appears in the *Supplement* at page 63.