

As time went on, however, results improved. Table II contains an analysis of the cases dealt with during the last six months of the year 1924, drawn up by my house-surgeons, Dr. J. I. Noble and Dr. W. F. Jones, at the Liverpool Stanley Hospital and Brownlow Hill Infirmary. The cases were treated by combined suture and gastro-enterostomy; 11 made uneventful recoveries, 1 died three weeks after operation from residual abdominal abscess; all were of the male sex.

TABLE II.—Analysis of 12 Cases Operated on during the last Six Months.

Age.	Hours between Perforation and Operation.	Site of Perforation.	Age.	Hours between Perforation and Operation.	Site of Perforation.
46	8½	Lesser curvature of stomach.	20	4½	Duodenum.
21	3½	Duodenum.	33	7½	Duodenum.
47	23½	Duodenum, death	38	3½	Duodenum.
40	25	Duodenum.	24	6	Duodenum.
22	3	Duodenum.	28	2	Posterior surface of stomach.
40	9	Pylorus.	59½	8	Duodenum.

Mortality = 8 per cent.

In conclusion, I do not in any way suggest that the combined operation should be the routine treatment; it depends entirely on opportunity and circumstances. If one is constantly undertaking gastric surgery, and the facilities are favourable, I think the combined operation is both an immediate and remote advantage to the patient, and should be done if the patient's condition will allow it. On the other hand, it should not be undertaken by the "occasional" operator, or in circumstances when warmth, light, skilled assistance, or suitable operative facilities are absent. Simple closure is then the safest method. The complication of bronchopneumonia undoubtedly increased mortality in my earlier cases, but it has latterly almost entirely become eliminated by suitable preparation of the theatre and patient and by careful after-treatment.

#### REFERENCES.

<sup>1</sup> H. J. Paterson: *Surgery of the Stomach*, p. 154. <sup>2</sup> John B. Deaver and David B. Pfeiffer: *Annals of Surgery*, April, 1921, p. 441. <sup>3</sup> G. Percival Mills: *BRITISH MEDICAL JOURNAL*, January 3rd, 1925, p. 12. <sup>4</sup> H. J. Paterson: *Op. cit.*, p. 171. <sup>5</sup> Moynihan: *Lancet*, 1923, i, 631. <sup>6</sup> Zachary Cope: *BRITISH MEDICAL JOURNAL*, January 17th, 1925, p. 139.

### TREATMENT OF THREATENED GANGRENE OF THE ARM DUE TO INJURY OF THE MAIN ARTERY.

BY

PETER McEWAN, M.A., M.B., F.R.C.S.Ed.,  
HONORARY SURGEON, BRADFORD ROYAL INFIRMARY.

IN the following two cases, seen several days after the axillary or brachial artery had been torn across, the extent of the threatened gangrene was greatly minimized by a simple method of treatment.

A man, aged 39 years, was admitted to Bradford Royal Infirmary on July 11th, 1923. Five days previously he had been getting off the back of a moving motor lorry, and had been dragged by his left arm for some distance. On admission, the left hand and forearm and the lower third of the upper arm were cold, swollen, and very tense, and did not show any evidence of circulation. The left axilla was occupied by a large, tense, fluctuating swelling, obviously a haematoma, due to rupture of a large vessel, probably the axillary artery. There was no bone injury. It was clear that the collateral circulation had succeeded in reaching only the upper two-thirds of the upper arm, and it appeared possible that the tension under the deep fascia had determined its limit. I accordingly made free incisions through the deep fascia of the arm, down as far as the wrist, so as thoroughly to relieve all tension. During the following ten days warmth gradually returned to the part, extending about one and a half inches further down each day, until it eventually reached the level of the proximal phalanges. Gangrene, however, appeared in the fingers, and presently involved the whole of the hand. Amputation was performed on August 6th at the wrist-joint. He was discharged from hospital on August 20th, and his wounds were all soundly healed by December 6th, his forearm being quite useful and showing no trophic changes. The fluid swelling

in the axilla became gradually and completely organized, with free movement.

On July 19th, 1925, I was asked to see a similar case with a view to giving an opinion as to the site of amputation for impending gangrene.

A child, aged 5 years, had, three and a half days before, sustained a severe fracture-dislocation of the right elbow. This was reduced and put up on a rectangular splint. Two days later the fingers were observed to be blue and cold, and the splint was removed and the arm watched. The condition was not due to tight bandaging. When I saw the child the hand and forearm up to beyond the elbow were quite cold, with some blebs on the skin below the elbow. The forearm up to beyond the elbow was very tense. There was a good deal of ecchymosis over the lower part of the brachial artery, which we presumed was torn. On the analogy of the previous case, I made very free incisions in the deep fascia over the whole area of tension. The flexor sublimis digitorum was found to be already gangrenous. Within twelve hours normal warmth had been restored as far as the wrist, and partial warmth, which soon became complete, in the hand and fingers. Both the flexor sublimis and the flexor profundus sloughed down to the radius, after which the wound healed. Suppuration occurred in the wrist-joint, in which, on October 31st, the date when a note was last made, sinuses still persisted. No amputation was necessary.

It may be deduced that a slight collateral arterial circulation existed after the accident in both cases, but that the tension obstructed the venous return, and thus there was a further increase of tension which inhibited the feeble arterial flow. The tissues bulged freely after the incision of the fascia, and this, together with the rapid improvement in the case of the child, justifies the inference that relief of tension was the essential point in treatment. The absence of interference with the actual lesion of the artery, leaving the collateral circulation as intact as possible, no doubt contributed to the successful result. In the case of the man the recovery of vitality after the limb had been practically or entirely devoid of circulation for days is remarkable.

## Memoranda :

### MEDICAL, SURGICAL, OBSTETRICAL.

#### NOVASUROL AND OTHER DIURETICS IN CARDIAC OEDEMA.

THE article in the issue of the *JOURNAL* of January 16th (p. 80) by Dr. C. G. Lambie on the diuretic action of novasurol interested me greatly. Following the lines suggested by Keith,<sup>1</sup> Rowntree,<sup>2</sup> and others I have, so far, treated two cases with striking results, the method employed only differing from that of Dr. Lambie in that ammonium chloride was used, both as a preliminary diuretic and also during the administration of the novasurol itself.

Case I was a woman, aged 67, with myocardial degeneration but no valvular disease. Extra-systoles were present. The lower limbs were enormously oedematous; the dropsical effusion extended to the subcutaneous tissues of the back and abdomen, and also slightly to the hands. A moderate degree of ascites was present, and there was also slight jaundice. Rest in bed over a period of some weeks, Karel diet, the administration of digitalis alternatively with other cardiac tonics, and the use of diuretics such as theobromine sodium salicylate and theocin all failed, the oedema growing steadily worse. Ammonium chloride was then administered in capsules, to a daily total of 5 grams, in divided doses. Low salt fluid diet alone was allowed, and the daily intake restricted to 800 c.cm. By this means a slight diuresis was induced. Novasurol was then given on four occasions at intervals of three days, by the intramuscular route, each dose consisting of 0.5 c.cm. Following each injection the urine increased markedly in amount, with a corresponding decrease in oedema, but unfortunately the attendants could not be prevailed upon to preserve the total for measurement. At the end of thirteen days all oedema had completely disappeared, to the relief of distressing symptoms formerly present. Gradual myocardial failure, however, supervened, and the patient died some days later, without, however, a return of the dropsy.

Case II was that of a man, aged 46, suffering from chronic nephritis with salt retention, albumin being present in the urine to the extent of 4 per cent. The legs were greatly swollen, with severe ascites and oedema of both lung bases. Treatment was adopted on similar lines with fluid intake restriction to 28 oz., and the urine, which before treatment amounted to 25 oz. a day,

<sup>1</sup> Keith, Barrier, and Whelan: The Diuretic Action of Ammonium Chloride and Novasurol in Cases of Nephritis with Oedema, *Journ. Amer. Med. Assoc.*, September 12th, 1925.

<sup>2</sup> Rowntree, Keith, and Barrier: Novasurol in the Treatment of Ascites with Hepatic Disease, *Ibid.*, October 17th, 1925.

rose immediately under the administration of ammonium chloride to a daily output of 30 oz. Novasul was given intramuscularly, on the first occasion 0.5 c.cm. and on the second 0.75 c.cm. After the former the output of urine in twenty-four hours rose to 100 oz., and after the latter to 200 oz. The patient was greatly relieved, and only slight oedema of the legs remained.

I was much impressed by these results, and feel that novasul is destined to prove a very valuable diuretic. It appears to act more rapidly in the relief of ascites than in that of general tissue oedema, and thus may prove more useful still in cases of portal cirrhosis. I have so far found only one toxic disadvantage—namely, the production of a profuse watery diarrhoea for some hours after its administration. This occurred in Case 1, and I have since thought it wise to warn patients of this possibility beforehand.

RICHARD HOWARTH, M.B., Ch.B. Edin.

Stalybridge.

#### A FORTUNATE ESCAPE FROM SYMPATHETIC OPHTHALMIA.

IN July, 1925, a patient presented himself with a piece of chisel firmly embedded in the left cornea; at the end of the wound nearest the pupil there was some escape of aqueous humour and prolapse of the iris. After thorough cleansing with warm boric lotion, the iris was replaced and a fine catgut suture inserted in the cornea; the eye was next treated with 10 per cent. argyrol, covered with a shade, and a plane lens of green glass was fitted over the other eye. He was sent to an ophthalmic surgeon on the third day, who advised immediate excision; the patient refused operation, so was treated on general lines—namely, warm boric fomentations, with atropine "drops." The ophthalmoscopic picture consisted of a grossly injected retinal system, visual acuity was limited to counting fingers at a distance of 1 metre in the injured eye, and 6/9 in the uninjured eye. For twenty-one days he seemed to make little progress, and complained of frontal headache, nausea, and "floating bodies." His fundi were examined every other day, and treatment with boric fomentations, atropine, and 10 per cent. argyrol continued; in addition, his diet was restricted, saline purges given, and oxyquinolthen cachets, which latter relieved his frontal headache.

Not until September 1st did his signs and symptoms show real improvement; on September 10th spectacles were provided to correct his amblyopia, and his vision was 6/12 and 6/9 in the injured and uninjured eyes respectively. He is now working on a stationary engine and carrying out his duties effectively.

I believe that this patient narrowly escaped sympathetic inflammation; it is obvious that he had a marked degree of sympathetic irritation. Although non-excision of the affected eye was not followed by disaster, I am still convinced that in such cases as this the policy of "wait and see" is very apt to develop into "wait and see not."

Blyth.

LAWSON L. STEELE.

#### TORSION OF FALLOPIAN TUBE.

MR. JOHN C. JEFFERSON's account of a case of torsion of the Fallopian tube (January 9th, p. 55) leads me to report a similar case.

A single woman, aged 23, was admitted to Cheltenham General Hospital on November 5th, 1925, suffering from an acute condition, thought to be most probably appendicitis. The condition started four days before admission with pain in the left iliac fossa going over to the middle line below the umbilicus. There had been vomiting and pain on micturition for three days. Menstruation had been regular, the last a fortnight before admission.

The abdomen was distended below the umbilicus and tender across from the left side to the right. On rectal examination a tender swelling could be felt in the pouch of Douglas. Temperature 100°, pulse 100.

On opening the abdomen abundant free fluid was found in the pelvis. The left tube was swollen and nearly black from strangulation, due to twisting on itself twice round its long axis, the point of torsion being just opposite the ovary, which was normal. The right tube and ovary were normal; the uterus was slightly enlarged. The tube was removed, and the patient made an uninterrupted recovery. There was no evident cause for the torsion.

I am indebted to Mr. Braine-Hartnell for permission to report this case.

Cheltenham.

JAMES C. GILLIES, M.B., Ch.B.

## Reports of Societies.

### MANIPULATIVE TREATMENT IN MEDICINE AND SURGERY.

At a meeting of the Medical Society of London on January 25th, with the President, Sir HOLBURN WARING, in the chair, a discussion was held on manipulative treatment in medicine and surgery.

MR. W. ROWLEY BRISTOW, in opening, said that this subject should lend itself well to discussion, if only for the reason that every year or two brought forward a heated controversy in the medical or lay press, or both, on the claims of bonesetters. In the lay press the names of distinguished, usually titled, persons were given who were invariably described as being grateful to an unqualified practitioner. The public had been led to believe by the lay press that bonesetting was not included in the armamentarium of the qualified medical man. It was a platitude that adequate treatment necessitated accurate diagnosis, which in its turn depended upon an understanding of the anatomy and pathology of the part affected. Was it true that these unqualified practitioners, whose fundamental grounding was necessarily inadequate, succeeded where the qualified man failed? On the contrary, everyone could recount instances of patients who had failed to benefit at the hands of the bonesetter and had responded readily and well to the recognized medical practitioner. Everyone could also tell of egregious mistakes on the part of the bonesetter. Mr. Bristow related several; one concerned a child, admitted under his care at St. Thomas's, who had been under a bonesetter for some months because she walked badly, and manipulative treatment of the spine had been ineffectual because the child was suffering from congenital dislocation of the hip. The inability to make a correct diagnosis in a simple case was the greatest danger of unqualified practice. He knew of another case of foot-strain in a lady who taught folk-dancing. The bonesetter told her that the ankles, knees, hips, and spine were all "out," and that two weeks' treatment in his home was necessary. Her suspicions were aroused when she discovered that the very same cure had been offered by the same man to her husband, who had suffered from osteoarthritis for many years and was a hopeless cripple. Thus there was reason to believe that the failures of the unqualified were many, but, on the other hand, he did not wish to imply that the qualified man always succeeded and the bonesetter always failed. One man might fail with a patient when another, no better armed and with no greater experience, succeeded. Many men with no very obvious qualifications succeeded well, while the more highly qualified were failures. Personality and experience counted for much, and often gave good results, even when the work was empirical; but if empiricism rather than knowledge was the foundation on which a man worked errors must creep in. The unqualified practitioner sometimes scored because he took risks which the qualified man would not take. The qualified man, if not sure of his diagnosis, had to play for safety. The speaker went on to say that from time to time when manipulative surgery was discussed by members of the profession it was hinted that there was some manipulative art which had been handed down outside the ranks of the regular practitioner, and which he would not, or could not, acquire. The matter was really very simple and had been admirably stated by Sir Robert Jones: "There are no hidden or mystic rites in the art of bonesetting." The methods of manipulative treatment were not absorbed into the general practice of medicine because the teachers in the medical schools had not recognized their value. That was true in the past and to some extent to-day. The field for manipulative surgery was largely in the treatment of minor injuries, and, to a less extent, chronic joint disease. This was the type of condition which lost its perspective in hospital practice, where the graver conditions arrested the attention of the surgeon. There would seem to be no room or time in hospital for adequate attention to those minor disorders, which, however, ceased to be minor as soon as the student

GEORGE ROBINSON, M.R.C.S.,  
Bedford.

DR. GEORGE ROBINSON passed away at his residence in Bedford on January 16th at the age of 87 years. He succeeded his father in the practice, which he cultivated with great competence, shrewdness, and natural kindliness. He received his education at Bedford Grammar School and St. Bartholomew's Hospital, where he commenced his medical studies in 1856, qualifying M.R.C.S. and L.M. in 1860. He was a devoted member of the British Medical Association.

For many years he was deputy chairman of the Bedford County Hospital, and he was J.P. for the town of Bedford. Dr. Robinson was endowed with physical energy to an unusual degree. He had on more than one occasion, when a student at St. Bartholomew's, walked all the way home to Bedford. He was fond of boxing, and many a boxing episode has he recounted to the writer of this notice. He was not only aggressive as a pugilist, but the same aggressiveness was marked in his whole-hearted friendship—he was with his friends heart and soul. He was the ideal companion for a tiger-hunt, or any exploit needing daring and go-aheadness. At the age of 65 Dr. Robinson frequently swam a mile before breakfast, then during the day he would play three rounds of golf, and dance for two hours after dinner. He was a keen huntsman, a good billiard-player and fencer—a sportsman, indeed, of no mean order. He was all but an abstainer from alcohol, but he consumed tobacco vigorously almost up to the end. He used to laugh when reminded that his head was like that of Julius Caesar in the British Museum, but the likeness was striking. A few years ago he sustained a fracture of the femur whilst playing golf; the fracture never quite united, and a period of semi-invalidism set in; for a considerable time he had been confined to bed, where he read and smoked and enjoyed the consolations and devoted attention of Dr. Bell, his successor in the practice. He married Miss Cookson of Luton in 1862. There were no children. His wife died in 1911. After a service at St. Paul's Church his remains were interred in Bedford Cemetery.

EDWARD WOOD, M.R.C.S., L.R.C.P., L.S.A.,  
Enfield.

DR. EDWARD WOOD, who died on January 14th, had a history which is somewhat unique and perhaps worth recording. He was a member of the London Stock Exchange for about twenty years, but from his boyhood was always most interested in everything connected with medicine. Later he determined to become a student, and, to this end, studied for and passed the London matriculation when about 35 years of age. He then gave up his City life and entered King's College Hospital, being strongly advised by the then dean not to start on such a career so late in life; but his enthusiasm was so great that he entered also at St. Bartholomew's, using both medical schools to achieve his object. He took the diplomas of L.S.A. in 1884, of M.R.C.S. in 1885, and of L.R.C.P. Lond. in 1886. He became a member of the British Medical Association, and settled down in Enfield, where he quickly obtained a considerable practice amongst all classes, and was especially beloved by his poorer patients, whom he always treated with the greatest kindness, and, it might be added, with the greatest liberality. He took a partner in 1893, finding his practice growing larger than he could carry on agreeably single-handed. He retired in 1897, but continued to reside in Enfield. However, this step in no way divorced him from his interest in the profession, for he sat for hours daily in his library reading medical literature, and as far as possible keeping himself up to date. Nothing pleased him more than receiving visits from his former colleagues and talking over medical matters with them, confirming his opinions by producing the latest textbook, which he would gladly lend to his visitor for perusal at home. Thus passed nearly thirty happy years amongst his books, in his rose garden, and at his electric piano-player—always of the latest type, and for which he had a most extensive collection of records of the best music.

Until over 80 years of age he regularly attended the annual dinner of the local Medico-Ethical Society, but to the sorrow of all its members advancing years, bringing failing sight and hearing, precluded his attendance on the last occasion. Many very sympathetic references were made about "dear old Wood" by those present. He passed away painlessly, aged 82, leaving a widow and two sons, one of whom is in the medical profession.

It is with regret that we announce the tragic sequel to an unfortunate mishap in the *post-mortem* room. Dr. C. IRIS FOX died at the Royal Free Hospital on January 21st, as a result of pricking her finger while conducting such an examination there several weeks ago. Miss Fox was the daughter of Dr. R. Fortescue Fox. She studied at the London School of Medicine for Women, and took the diplomas of M.R.C.S., L.R.C.P. in 1915. The following year she graduated M.B., B.S. of London University, and in 1922 obtained her doctorate. Dr. Fox held the posts of senior assistant pathologist and assistant director of pathological studies at the Royal Free Hospital. She was formerly assistant pathologist at Swansea General Hospital and second assistant pathologist at St. Mary's Hospital. She had also been medical registrar at the Royal Free Hospital. She was the author of an article on lymphadenoma and tuberculosis, which was published in the *Lancet* in 1921. Among her contemporaries Dr. Fox was admired for the painstaking thoroughness which characterized all her work. The sadness of such a mishap is intensified by the high standard of Dr. Fox's work, which pointed most definitely to an eminently successful future.

## Universities and Colleges.

### UNIVERSITY OF OXFORD.

#### *Rolleston Memorial Prize, 1926.*

THIS prize, which is now of the value of about £100, is awarded every two years under the conditions stated below, for original research in any subject comprised in the following list: animal and vegetable morphology; physiology and pathology; and anthropology. No candidate will be eligible (1) who has not either passed the examinations for the B.A. degree or the B.M. degree at Oxford, or for the B.A. degree or the M.B. degree at Cambridge, or been admitted as a candidate for the degree of B.Sc. at Oxford or as an advanced student for the degree of B.A. at Cambridge; (2) who has exceeded a period of six years from attaining one of other of these qualifications, or from his attaining the first of such qualifications, if he has attained more than one; (3) who has exceeded ten years from his matriculation.

The next award will be made in Trinity Term, 1926. Candidates wishing to compete must forward their memoirs to the Registrar of the University of Oxford before March 31st. The memoirs may be printed, typewritten, or in manuscript, should be inscribed "Rolleston Memorial Essay," and should bear the name and address of the author; memoirs already published are admitted to the competition. No account will be taken of any research which has not been prosecuted by the candidate subsequent to his matriculation.

At a congregation held on January 21st the following medical degrees were conferred:

B.M.—R. Lewthwaite, K. G. Norton.

### UNIVERSITY OF CAMBRIDGE.

At a congregation held on January 22nd the following medical degrees were conferred:

M.D.—F. R. Winton, \*C. J. Wilson.

M.B., B.Chir.—N. F. C. Burgess.

M.B.—J. Gray.

B.Chir.—The Hon. C. B. Buckley, R. T. Chadwick, G. L. F. Rowell, R. W. Cunningham.

\* Admitted by proxy.

### UNIVERSITY OF LONDON.

APPLICATIONS for the Graham scholarship in pathology must be sent in to Sir E. Cooper Perry, M.D., Principal Officer, University of London, South Kensington, S.W.7, before March 14th. The scholarship (which is of the value of £300 per annum, in the first instance, for two years) was founded under the will of the late Dr. Charles Graham to enable a young man to continue his pathological researches and at the same time to secure his services to the School of Advanced Medical Studies connected with University College Hospital as a teacher under the direction of the Professor of Pathology. Further particulars can be obtained on application to the Academic Registrar at the University.

## UNIVERSITY COLLEGE HOSPITAL.

Four lectures in the history of medicine (illustrated by lantern slides) will be delivered at University College Hospital Medical School by Dr. Charles Singer on Thursdays, February 4th, 11th, 18th, and 25th, at 4.15 p.m. The first will deal with the history of malaria, the second with the history of gout and diabetes, the third with the history of rickets, and the last with the history of small-pox. The lectures are open to all medical students of the University of London.

## UNIVERSITY OF ST. ANDREWS.

At the graduation ceremonial held on January 15th the following degrees and diploma were conferred:

M.B., CH.B.—Dorothy H. M. Ames, Mrs. Margaret S. Armit (*née* Marshall), A. P. R. Borrowman, Winifred N. Daggart, Janet L. M. Inglis, Janet E. Luke, S. C. McPherson, J. H. Malloy, Jane M. Miller, D. Murray, P. J. O'Brien, W. D. Pollard, J. M. I. Ratray, W. O. Reid, Renée Ritchie, E. H. T. Rutherford, Jean R. Sheriffs, Jean J. Smith, Dorothy G. Stewart.  
M.D.—M. L. Ahuja, A. A. B. Scott,  
D.P.H.—Hermina M. Morrison.

## UNIVERSITY OF DUBLIN.

## TRINITY COLLEGE.

At the later winter commencements in Hilary Term, held on January 16th, the following degrees were conferred:

M.B., B.Ch., B.A.O.—C. Lord-Flood (*antea licentiatius*), W. J. van Zijl, Margaret O'Neil (*nunc* Hill) (*in absentia*).

## The Services.

## TERRITORIAL ARMY MEDICAL OFFICERS' ASSOCIATION.

THE Territorial Army Medical Officers' Association has been formed to provide an organization for the consideration of matters of interest to Territorial medical officers, active and retired. We are asked to remind officers that the first annual dinner will be held on Friday, February 12th, at 8 p.m., at the Café Royal, Regent Street. Tickets (12s. 6d., without wine) can be obtained from Colonel M. B. Ray, D.S.O., M.D., at 37, Russell Square, London, W.C.1. The guests of honour will be Lieut.-General Sir Hugh S. Jeudwine, K.C.B., Director-General of the Territorial Army, and Lieut.-General Sir William B. Leishman, K.C.B., Director-General of the Royal Army Medical Corps.

## Medical News.

DR. J. W. MCNEE will lecture for the Fellowship of Medicine on the treatment of renal disease on February 4th, at 5 p.m., at 11, Chandos Street, W. A course in venereal diseases at the London Lock Hospital begins on February 1st and will continue through the month. From February 8th to 27th a combined course in diseases of children will be given by the Paddington Green Hospital, Victoria Hospital, and the Children's Clinic. The London Temperance Hospital has arranged a course from February 8th to 19th (4.30 to 6 p.m.). An intensive course in medicine, surgery, and the specialties will be held at Queen Mary's Hospital, Stratford, from February 15th to 27th. The following courses will be held in March: medicine, surgery, and the specialties at the Hampstead Hospital; bacteriology, Westminster Hospital; diseases of the chest, Brompton Hospital; gynaecology, Chelsea Hospital for Women; ophthalmology, Royal Eye Hospital; and tropical medicine at the London School of Tropical Medicine. Copies of syllabuses and of the general course programme may be had from the Secretary at 1, Wimpole Street, W.1.

THE inaugural meeting of the London Clinical Society will be held on Thursday, February 18th, at 8.45 p.m., at the London Temperance Hospital, Hampstead Road, N.W., when Sir Arbuthnot Lane, Bt., will give an address entitled "Is Civilization a Failure?" All medical men and women will be welcomed. The Honorary Secretary is Dr. Philip Figdor, 150, Harley Street, W.1.

THE British Science Guild will hold a conversazione at Carpenters' Hall, Throgmorton Avenue, London, on Thursday, February 11th, at 4.30 p.m. Brief addresses will be given on the scientific approach in administrative problems, the use and abuse of the "conference" instrument, losses from avoidable fires, and losses from timber disease. Cards of admission can be obtained from the Secretary, British Science Guild, 6, John Street, Adelphi, W.C.2.

THE annual dinner of the Hunterian Society of London will be held at the Hotel Victoria, Northumberland Avenue, on Thursday, February 11th, at 7.30. Among the guests expected to be present are the Lord Mayor and Lady Mayoress of London, and the Bishop of Kensington.

A STONE tablet in memory of Sir G. Anderson Critchett, Bt., surgeon oculist to the King, who died on February 9th, 1925, is to be erected in the School Chapel at Harrow, from the design of Sir Charles Nicholson.

DR. JOHN BEATTIE, research assistant and demonstrator of anatomy at University College, London, has been appointed anatomist to the Zoological Society of London, with charge of the prosectorium at Regent's Park.

DR. E. R. A. MEREWETHER of Gray's Inn was called to the Bar on January 26th.

THE Educational Health and Food Campaign, inaugurated in 1907, is now being continued by the People's League of Health, at the request of the council of the Bread and Food Reform League. Efforts are made to circulate information about the most nourishing and economical foods and the value of finely ground wholemeal bread.

DR. E. HALFORD ROSS, medical member of the Council of the Industrial Welfare Society, is going to South Africa for a year to make observations on miner's phthisis on the Rand. From Africa he will go to India to advise on measures against malaria and mosquitos in some of the tea-growing industries in Assam.

THE fifth International Congress of the Science of Heredity will be held in the second half of next September at Berlin, under the presidency of Professor D. E. Bauer. This will be the first international congress held in Berlin since the war.

A REPORT on paraffin dermatitis and cancer, including its incidence, prophylaxis, and treatment, is published by the International Labour Office at Geneva, as one of its series (No. 20) of pamphlets in the *Encyclopaedia of Industrial Hygiene*. The pamphlet, and others of the series, may be obtained from the London Branch of the Office, 26, Buckingham Gate, S.W.1.

ACCORDING to statistics recently issued by the Metropolitan Insurance Company the mortality from small-pox in Canada and the United States, which was under 1 per cent. in 1923, rose to 1.5 per cent. in 1924 and 3.5 per cent. in the first half of 1925. The increasing severity of the disease was also shown by the fact that in one place 44 out of 97 patients died.

## Letters, Notes, and Answers.

All communications in regard to editorial business should be addressed to **THE EDITOR, British Medical Journal, British Medical Association House, Tavistock Square, W.C.1.**

ORIGINAL ARTICLES and LETTERS forwarded for publication are understood to be offered to the **BRITISH MEDICAL JOURNAL** alone unless the contrary be stated. Correspondents who wish notice to be taken of their communications should authenticate them with their names, not necessarily for publication.

Authors desiring REPRINTS of their articles published in the **BRITISH MEDICAL JOURNAL** must communicate with the Financial Secretary and Business Manager, British Medical Association House, Tavistock Square, W.C.1, on receipt of proofs.

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.

THE TELEPHONE NUMBERS of the British Medical Association and the **BRITISH MEDICAL JOURNAL** are **MUSEUM 9861, 9862, 9863, and 9864** (internal exchange, four lines).

THE TELEGRAPHIC ADDRESSES are:

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

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

MEDICAL SECRETARY, *Mediscera Westcent, 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, Drumsheugh Gardens, Edinburgh (telegrams: *Associate, Edinburgh*; telephone: 4361 Central).

## LETTERS, NOTES, ETC.

## THE NATURE AND ORIGIN OF CANCER.

DR. FRANK B. SKERRETT (Stratford, E.15) writes: Notwithstanding the brilliant researches of Dr. Gye, many of us who have given some time and thought to the problem still remain unconvinced as to the microbic nature of cancer—and not without reason. There are many well known grounds for disbelief in any specific organism as a cause of cancer, but I do not propose to enumerate them here. The school of adherents to the parasitic theory (largely in evidence in the early nineties) has been rapidly decreasing, and many pathologists of to-day have now definitely discarded it, so that it would appear that Dr. Gye's discovery—with the interpretation put upon it—must have fallen as a bomb-shell among them. Urged more by doubt than any desire to depreciate so valuable a piece of work, I venture to put forward