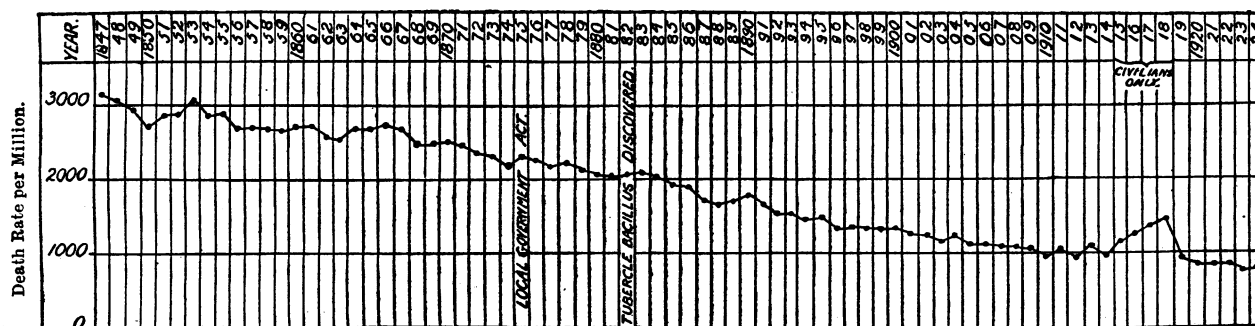


CHART SHOWING THE DEATH RATE FROM PHTHISIS FOR THE YEARS 1847 TO 1924.



nine cases out of ten neglected appendicitis; persistent headaches, due to errors of refraction.

Lupus, which is now treated early and successfully, and gastric ulcer, which is now actually cured in hospital by the physician or, failing him, by the surgeon, may be only apparently less frequent, for they, like many other conditions, have possibly, on account of their long duration, given rise to a false impression of their prevalence. For example, one patient with gastric ulcer would require many attendances over a long period of time and leave on the mind of the medical attendant the impression of many cases, with the consequence that when such a case is cured early in its life it may incline one to think that gastric ulcers are less frequent than they used to be.

Again, there are some conditions that may appear to be less frequent because it is no longer fashionable to look for them or to talk about them—such, for example, as movable kidney and displaced uterus, both at one time the delight of the seeker after sympathy and for the doctor dividend-earning ailments. So, no doubt, in due time "blood pressure" will become a less fashionable and less prevalent complaint.

Although it is not a disease, I almost think that we might add to the list of disappearing diseases senility; if it is not disappearing there is much evidence that its onset is postponed by several years.

There is little profit in merely registering the fact of the decline of a disease unless at the same time we can form some idea of the causes of that decline; in the case of the zymotic diseases this is not so difficult, though it is by no means easy to assess the value of the part played by the different agents. It is at any rate obvious that each section of the medical profession—the laboratory worker, the clinician, and the public health administrator—has had an important share in the campaign. Medicine in the fruition of its work has been helped by the State; the State has been dependent on the medical profession, but the brunt of the battle has fallen on the medical man, who has had for long weary years to educate and to persuade an unwilling, an unbelieving, and a not always grateful, public that if only it will listen and help it may be relieved of many of its ills.

With the good old times, whose passing many lament, have passed diseases and conditions of life that none can want back; with improving medical knowledge and service and conditions of life we may look with hope to the disappearance of still more diseases.

Are we ever justified in concluding that any diseases naturally get less virulent and then disappear? What is the reason of the undoubted milder type of some of the infectious diseases—such, for example, as small-pox? Is it due to vaccination and an inherited immunity? If so, why in the recent epidemic in Gloucester was there no difference in the character of the disease in the unvaccinated, whether they were the children of vaccinated parents, or of one or two generations of unvaccinated parents?

Why is it that scarlet fever has become so much less serious? There can be no question of artificial immunity, and one can hardly think that the mere isolation of some of the cases can account for this alteration. Although, judging by the analogy of diphtheria, it may be argued that isolation may have some influence in affecting virulence, the earlier cases in an epidemic of diphtheria are

generally of a very mild type; as the epidemic increases the type becomes more virulent; if, however, the earliest cases are effectively treated and isolated there is not the same increase in virulence.

Is not the disappearance of an infective disease due to altered conditions which render its continuance difficult? Given the old conditions, would it not reappear?

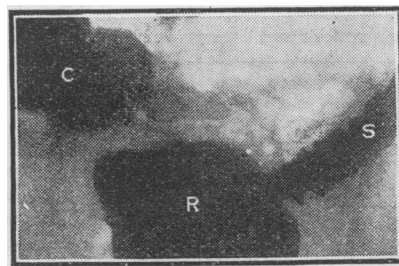
Are we to look forward to a time when, having been freed from all diseases, we shall, like the antivaccinators, lulled into a false sense of security, forget the forces that drove them out, and, relapsing into the old conditions—an unprepared, a non-immunized, and non-resisting community—be attacked with devastating effect?

Memoranda : MEDICAL, SURGICAL, OBSTETRICAL.

THE PREDIVERTICULAR STATE AND DIVERTICULOSIS.

THE recent interesting article by E. I. Spriggs and O. A. Marxer (January 23rd, p. 130) throws a considerable light on the etiology of diverticulitis of the sigmoid colon. The fully developed condition is well recognized by surgeons, but no satisfactory explanation of the train of events which leads up to the formation of the sacculi has been given previous to the report of Marxer in 1923. A recent case in which I have had the opportunity of seeing the colon at operation confirms and amplifies the observations they record in the article mentioned above.

The patient, a man aged 43, had suffered from the passing of loose motions for three or four years; in the latter part of this period he occasionally passed a little blood. Latterly he had a little vague discomfort in the left iliac fossa, but continued to work till brought to hospital, alarmed by the blood in his motions. He was sallow and anaemic. On abdominal examination a somewhat tender spastic colon could be felt in the left iliac fossa; by the rectum the mucosa felt velvety and inflamed. A barium enema of 70 oz. was given without pain, and the picture had all the characteristics mentioned by Spriggs and Marxer: passing out of the ampulla of the rectum there was a length of colon going for some four inches upwards and to the left. This segment was narrowed and its edges presented that peculiar spiky condition so well shown in their illustrations. The radiograph of this length of bowel conveyed to the eye the sense of a rigid walled tube with weak areas in it and contrasted strongly with the distensible colon, into which it passed above, which had the bold curves normal to the bowel.



C, Caecum. R, Rectum. S, Sigmoid.

Sigmoidoscopy was done, but the tube could not be introduced past the rectum owing to pain and inability to distend the bowel properly, while the view was constantly spoilt by blood-stained mucus coming from the bowel above. Laparotomy was performed under spinal anaesthesia. The sigmoid colon, on examination, showed no gross changes, no sacculi, no excessive deposit of fat, no narrowing. Its walls were rather thicker than normal, however, and the areas between the longitudinal bands showed a peritoneum that was distinctly injected and a little oedematous.

While under examination a most extraordinary sequence of events occurred, which in my experience is quite unique. At one point the bowel suddenly narrowed to half its previous diameter; this narrowing spread up and down for three or four inches, the bowel in this area becoming the size of the index finger and quite as firm. It was so rigid that it resisted flexion like a string of large beads very tightly threaded. While the spasm lasted many tiny sacculi appeared between the longitudinal bands; these were each segments of a circle about a third of an inch or less in diameter and lay regularly like beads along the sides of the gut. In a few seconds the spasm passed off and a nearly normal bowel remained with faint evidence of the tiny projections indicated for a few seconds by the altered blood supply at their sites owing to the tension to which the peritoneum had been subjected. The cycle of spasm repeated itself thrice during the time the abdomen was open.

In the absence of any real indication for removing the bowel, appendicostomy was performed in order to allow of local treatment of the mucosa, which from the presence of blood and mucus was evidently inflamed.

This case would appear to be an example of the pre-diverticular state and presents the clinical and radiographic picture that Spriggs and Marxer have described; they emphasize the part that infection plays in preparing the bowel wall, but do not put stress on the second factor which this case exhibits so well—the remarkable local spasm which would appear to be the second link in the chain. The third incident, the herniation, may or may not appear. One sees from time to time cases in which a length of the colon appears rigid and fibrous without diverticula; in these cases the infection would appear to have gone on to fibrosis without herniation. As to whether the tiny projections seen at operation were incipient herniations, I think they were too regular in size and position for this to be the case. Their appearance makes it more probable that they were due to local spasm of the coats of the bowel producing minute haustra like those normally seen on a larger scale in the colon higher up. The sacculi in diverticulitis are variable in size and irregularly situated and for the most part have narrow necks.

In another case of mine with definite sacculi of considerable size the same oedema and injection of the bowel wall was present, and whilst the bowel was being handled a tiny diverticulum, so thin-walled as to be translucent and not more than 4 mm. long by 2 mm. in diameter, shot out like a glove finger when the bowel was squeezed, only to relapse as the pressure was relaxed. This tiny thin-walled sacculi, appearing and disappearing with spasm and relaxation, would seem to be a further stage in the evolution of a diverticulum.

The sequence of local infection of the bowel wall and violent local spasm followed by herniation appears to offer a logical explanation of the etiology of a condition which has hitherto been somewhat baffling to those accustomed to meet with it.

Birmingham.

SEYMOUR BARLING.

THE BLOOD SUGAR IN A CASE OF ADDISON'S DISEASE.

A low blood sugar and a raised tolerance are to be expected in Addison's disease, but it appears that very few actual determinations have been recorded. For this reason I venture to submit the following case. The patient was in the Radcliffe Infirmary, Oxford, under Dr. Waters, to whom I am indebted for permission to make the blood sugar estimations.

A married woman, aged 35, with four children, presented most of the classical signs and symptoms of Addison's disease. In January, 1925, she began to suffer from diarrhoea and some abdominal pain, and the menses ceased. These symptoms persisting, she was admitted to the Radcliffe Infirmary. When seen in June, about a fortnight before her death, she was thin and wasted, though not suffering from extreme asthenia. Her skin, which, she said, had always been somewhat dark, was everywhere deeply pigmented except upon the dorsal surfaces of the feet. The buccal mucous membrane was pale, and not pigmented. The chest showed no abnormalities. The abdomen was enlarged, especially in the lower part, and several small masses were felt near the umbilicus; no ascites was present at the time of examination, though shifting dullness had been noted on admission. The systolic blood pressure had been recorded on several occasions and lay between 88 and 100 mm. of mercury. Some fever was present. The urine contained a trace of albumin. The faeces had been examined once for tubercle bacilli, with a negative result, and a blood count had given the following figures: red blood corpuscles 4,220,000, white blood corpuscles 7,600, haemoglobin 52 per cent., colour index 0.6. The diagnosis was Addison's disease, secondary to tuberculous peritonitis.

A glucose tolerance test was made out on June 12th. The fasting blood sugar was 0.08 (grams per 100 c.cm.). This is low, the normal being 0.09 to 0.11. After taking 50 grams of glucose, the figures obtained were as follows:

Time after Glucose.	Blood Sugar.
30 minutes 0.11
45 minutes 0.11
1 hour (spoiled)
1 hour 30 minutes 0.11
2 hours 0.08

No glycosuria resulted. The treatment included injections of adrenaline, but none were given for twenty-four hours before the test.

Although one determination was spoiled, the remainder are quite sufficient to show that the sugar tolerance curve is remarkably flat, in accordance with a raised tolerance for glucose. Maclean's method was employed; as regards accuracy, a large number of control estimations, using standard glucose solutions, had shown my mean error to be ± 5 per cent., with a maximum error of ± 10 per cent.

The patient died rather suddenly on June 26th. There was no autopsy.

I desire to thank Dr. Waters for allowing me to examine and report on this case.

Wokingham.

E. F. CHAPMAN.

A NEW OCCUPATIONAL BURSA ("DUSTMAN'S" BURSA).

MANY occupational bursae have been described—the housemaid's, the miner's or student's, the porter's, and others—but for the first time I have recently seen one due to the occupation of a dustman. It will be observed that a dustman not infrequently has a short ladder by the side of his dust-cart, and that he mounts two or three rungs of this, and then leans with the upper third of his tibia against one of the higher rungs, so as to get a purchase to enable him to tilt the dust from the receptacle into the cart. The accompanying photograph shows the condition better than any description. On the left leg will be seen the adventitious bursa, while on the right leg will be observed the roughened skin at the site where the intermittent pressure has been applied.



W. McADAM ECCLES, M.S.Lond., F.R.C.S.,
Surgeon to St. Bartholomew's Hospital.

RASH FOLLOWING BARBITONE-SODIUM.

BARBITURIC acid or its derivatives are so much used now as hypnotics that the record of a very marked rash following comparatively small doses may be of interest.

The patient, an adult, was given 10 grains of medinal (barbitone-sodium) every night for three nights, after which a rash appeared on the extensor surface of the arms and legs below the knee. The rash was dark red and papular, and accompanied by considerable itching. As the use of medinal was not then associated with the rash it was continued for three more nights, making a total dose of 60 grains in six days. The result of this was that the rash became more marked, and there was oedema of the parts affected, but the rash did not spread beyond the situations described.

On reading in Martindale's *Extra Pharmacopoeia* that the barbitone series "may produce erythema" the drug was discontinued, and the rash started to fade, disappearing in seven days, with slight desquamation.

Eastbourne.

P. W. MATHEW.

SACCHARIN IN DISPENSING.

DURING the late war saccharin came into considerable prominence as a substitute for sugar; nowadays it is occasionally given to diabetics as a sweetening agent for tea, coffee, etc., but otherwise it never appears, so far as I can ascertain, to have been used in therapeutics. It occurred to me that its intense and "penetrating" sweetness (said to be 500 to 600 times that of sugar) might be employed to useful purpose for modifying the bitterness of many commonly used drugs. I therefore selected a series of preparations notorious for their disagreeable (and, more particularly, bitter) taste, and tried the effect of adding small quantities of saccharin. The results were encouraging: even added by itself it always produced marked improvement where bitterness was the principal objectionable feature; in combination with various flavouring agents it proved to be a valuable supplement. For example:

Magnesium sulphate: 0.3 grain of saccharin added to 1 drachm in an ounce of water produced a solution hardly distinguishable from sugar and water; 0.15 grain added to an ounce of "white mixture" made this preparation far more palatable.

Paraldehyde: 0.6 grain of saccharin added to 1 drachm in an ounce of water produced a marked improvement in taste. In combination with the juice of half a lemon it provides, I think, the most satisfactory method yet suggested of administering this nauseous drug.

Cascara sagrada (liquid extract): It was found necessary to add 2 grains of saccharin to a drachm (in an ounce of water) before any marked improvement was shown; even then the result was not satisfactory. After partly disguising a drachm of cascara with liquorice and glycerin, however, a grain of saccharin proved to be a valuable addition.

Quinine: Small quantities of saccharin (0.6 grain to each dose) made a welcome addition to various liquid preparations of quinine.

In the case of drugs owing their disagreeable character rather to "flavour" than to "taste," I was not surprised to find that saccharin was of comparatively little value—for example, tincture of valerian was scarcely improved. Creosote, however, in spite of its marked "burning" character, was improved by the addition of 0.6 grain of saccharin to every 3 minims.

For the purpose of disguising the bitter taste of certain medicines, therefore, it would seem that in saccharin we have an agent of which we might well make greater use. It is cheap, innocuous, does not (so far as I am aware) possess any serious incompatibilities, and is readily soluble in warm water.

Upper Norwood, S.E.

T. W. PRESTON, M.B.

Reports of Societies.

FOCAL SEPSIS.

At a general meeting of Fellows of the Royal Society of Medicine on February 15th, with the President, Sir STCLAIR THOMSON, in the chair, a discussion was held on focal sepsis as a factor in disease.

Professor G. R. MURRAY, in opening, referred to the increased attention which had been drawn to the subject of focal sepsis within recent years, and proceeded to deal with the modes in which such infection could initiate or affect the course of a malady, illustrating his remarks by suitable cases. In the first place bacteria might be discharged from some focus and conveyed mechanically to some other place. Secondly, bacteria might overcome local resistance at the focus of infection and be conveyed by the lymphatics to the nearest gland, which might arrest further progress, or they might pass direct into the blood stream from the septic focus or after the defence of a lymphatic gland had failed. Once in the blood stream bacteria might multiply and cause septicaemia, they might multiply only at some local spot, or without gaining any real footing they might produce slow but progressive changes in certain organs. Thirdly, bacteria might remain at the focus of infection and influence the body by their toxins which were absorbed. Examples of the first mechanical process were seen in the spread of infection by the fingers in cases of furunculosis, and in the way in which bacteria in the mouth could travel, for example, up Stenson's duct, or be swallowed and produce such lesions as gastritis and colitis, or be inhaled and produce, for example, gangrene of the lung. Direct absorption of bacteria into the blood stream gave rise to

the terrible cases of *post-mortem* septicaemia, or in some cases the organisms seemed to favour some particular spot for multiplying, as in malignant endocarditis. Professor Murray then dealt with the connexion between dental sepsis and arthritis, emphasizing the importance of root abscesses, which might be overlooked if the teeth were not carefully skiagraphed. He quoted Rosenow's work, which went to show that non-haemolytic varieties of streptococci produced fibrositis at points of muscular insertion, and referred to the relation between oral sepsis and severe anaemias. Certain work indicated that the organisms responsible for focal infection were selective in the tissues they attacked, and Professor Murray suggested that it might be a question of the oxygen and food supply available. Considering the large number of organisms present in the mouths and intestines of normal individuals, he thought that there must be some sort of acquired tolerance to these organisms in many cases. He referred briefly to the relation between focal sepsis and nephritis, and then described some cases where the continued absorption of toxins from empyemata had led to early amyloid change or to extensive clubbing of the fingers, which disappeared when these foci were effectively drained. Coming to the question of treatment, Professor Murray pointed out that the eradication of a septic focus was not altogether free from danger. He mentioned some interesting work in connexion with the effect of dental sepsis on the nursing mother, where feeding difficulties could be largely overcome by adequate dental treatment. Certain of the endocrine glands seemed to be affected by sepsis. Focal infection would certainly aggravate and retard the cure of such conditions as exophthalmic goitre, and acute pancreatitis might sometimes be the result of oral sepsis. Professor Murray referred briefly to the problem of systemic infections, such as infection of the bronchi or genito-urinary system, and with regard to intestinal stasis said that he believed it to be far less frequently the cause of disease than some authorities would admit. In summing up, he pointed out that the foci of infection could usually be found in the head, diverticula of the alimentary canal, or genito-urinary passages, while the organisms mostly concerned were either micrococci or members of the *B. coli* group.

Mr. HERBERT TILLEY dealt with chronic focal sepsis in the nose, ear, and throat. He described the paths of infection as direct, as by ingestion or inhalation, and indirect by the lymphatics or blood stream. Dealing first with the faucial tonsils, he defined a "septic tonsil" as one which had suffered from recurrent attacks of inflammation, and was associated with enlargement of the tonsillar lymphatic glands in the neck. The size of the tonsils was not of so much importance, since buried small tonsils appeared to be particularly liable to give rise to systemic infection. From the pathological point of view septic tonsils were associated with excess of polymorphonuclear leucocytes on the surface or in the substance of the gland, the presence of bacteria or debris in the gland not being of such great importance. Mr. Tilley described a striking case of chronic toxæmia completely cured by enucleation of "septic tonsils," and quoted Dr. F. J. Poynton's remarks with regard to the relationship between tonsillar infection and rheumatism in children. He described the various lesions which were produced by tonsillar sepsis, and then dealt with infection of the paranasal and accessory sinuses. It was only within the last few years, he said, that the infection of these sinuses in children had been adequately recognized, and the symptoms produced were very like those of chronic tonsillitis and explained those cases in which symptoms persisted after tonsillectomy. A great deal of pus could be swallowed from an infected sinus in the course of the day, and hence alimentary tract infections were commoner in these cases, and chronic cachexia, often closely simulating malignant disease, was often present. He referred to some work which went to show that cases of lobar pneumonia frequently had infection of the nasal sinuses, and suggested that this would explain the occurrence of cerebral abscess in cases of bronchiectases, since the nasal sinuses appeared to be frequently involved in this disease. He urged that physicians should constantly bear in mind

amazing: only a few months ago, in his quiet unostentatious way, he advanced a substantial sum of money, without security or interest, to help a colleague. Asked why he did it, his reply was that "he always looked upon a colleague in the profession as a gentleman of honour till he himself found otherwise." Much sympathy will be felt for his widow, who has so bravely helped and cheered him on through many difficult times. In the passing of Henry Gorrie the profession has lost one it can ill spare, and many of us a friend we shall never replace.

Dr. ALGERNON CHARLES WODEHOUSE NORTON died at St. Leonards on February 8th, aged 92. He was the son of the late Dr. Robert Norton, who practised in Hereford Road, Westbourne Grove, over fifty years ago, was educated at Middlesex Hospital, and took the L.S.A. in 1854 and the M.R.C.S. in 1855. After serving a term as house-surgeon at Middlesex Hospital he got an appointment as surgeon in the Turkish cavalry, and served in that capacity in the Crimean war. Returning to England after the war he graduated as M.D. at King's College, Aberdeen, in 1857, and also took the L.R.C.P. Ed. in 1859. He was for many years in practice with his father at Westbourne Grove, but had long ago retired from practice, and his name has long since dropped out of the *Medical Directory*. Dr. Norton must surely have been the last surviving medical veteran of the Crimea. All the medical officers who served as regulars in the Crimean war have long since joined the majority. The last R.A.M.C. survivor was Surgeon-Major A. E. T. Longhurst, who died on March 20th, 1925—nearly a year ago; and the last I.M.S. officer who served in the Crimea was Deputy Surgeon-General Benjamin Williamson, who died on February 21st, 1917—nine years ago.

Miss HELEN LOUISE BILLETT, who died on February 14th in a nursing home, after a long illness, received her medical education at the London School of Medicine for Women, whence she obtained the diploma I.S.A. in 1896 and the D.P.H.Camb. in 1898. Her professional life was devoted to pathology, and she held the appointment of pathologist to the Elizabeth Garrett Anderson Hospital for Women when it was called the New Hospital for Women. She later held appointments as assistant in the Clinical Research Association, and in the Laboratory of Pathology, Harley Street. A colleague writes that she bore a long illness with unflinching courage and patience, retaining a sense of humour and *acquaintance* to the end.

The deaths are announced of the following well known foreign medical men: Dr. Louis Mégevan, professor of medical jurisprudence in the Faculty of Medicine at Geneva; Dr. Morelle, professor of dermatology at the University of Louvain, and president of the Belgian Société de Dermatologie; Dr. Moussous, professor of children's diseases in the Bordeaux Faculty of Medicine; and Dr. Guilbaud, professor of clinical surgery in the medical school at Nantes.

Dr. NATHAN EDWIN BRILL, physician to Mount Sinai Hospital, New York, who gave his name to a disease now generally recognized as a mild form of endemic typhus, has recently died in his 65th year.

Universities and Colleges.

UNIVERSITY OF OXFORD.

At a congregation held on February 13th the following medical degrees were conferred:

B.M., B.Ch.—R. G. Mathews, D. O. Williams.

UNIVERSITY OF CAMBRIDGE.

At a congregation held on February 13th the following medical degrees were conferred:

M.Chir.—H. B. Stallard.
M.B., B.Chir.—A. Barker.
M.B.—K. F. T. Mills, A. H. Pearson.

UNIVERSITY OF LONDON.

The following have been recognized as teachers of the University in the subjects indicated: *St. Bartholomew's Hospital Medical School*, Dr. R. G. Cantl (bacteriology); *Guy's Hospital Medical School*, Mr. W. H. Trethowan (orthopaedic surgery); *Bethlem Royal Hospital*, Dr. C. C. Worster-Drought.

Mr. W. H. White, St. Mary's Hospital Medical School (or, failing him, Dr. A. H. Ferguson, East London College), and Mr. B. L. Worsnop, King's College (chairman), together with the external examiners, have been constituted the Board of Examiners in Physic for the first examination for medical degrees in 1926.

The regulations for the M.D. degree (Branch V—State Medicine) were amended by the deletion of the footnote (f) on page 250 of the Red Book, 1925-26, and page 236 of the Blue Book, September, 1925.

The ceremony of Presentation Day will be held in the Royal Albert Hall on Wednesday, May 12th, at 3 p.m., and the graduation dinner will take place the same evening in the Merchant Taylors' Hall, Threadneedle Street, at 8 o'clock.

A course of lectures on mental deficiency, supplemented by a course of clinical instruction, will be held at the central buildings of the University from May 31st to June 5th. Full particulars can be obtained from Miss Evelyn Fox, c/o University Extension Department, University of London, S.W.7.

The University Medal at the M.B., B.S. examination in November, 1925, has been awarded to Mr. W. R. Spurrell.

Applications for grants from the Dixon Fund, which are allocated annually for the purpose of assisting scientific investigations, must be sent in not earlier than April 1st nor later than the first post on May 15th. Further particulars may be obtained from the Academic Registrar.

Applications for grants from the Thomas Smythe Hughes Medical Research Fund must be received between May 1st and June 15th. Further particulars can be obtained from the Academic Registrar.

A course of lectures for medical practitioners on mental deficiency, supplemented by a course of clinical instruction, has been arranged by the University Extension Board in co-operation with the Central Association for Mental Welfare. The lectures will be given at the University, Imperial Institute Road, South Kensington. They will begin on Monday, May 31st, and end on Saturday, June 5th. They are intended for qualified medical practitioners, and more especially for those engaged as certifying officers to local authorities under the Mental Deficiency Act, 1913, as school medical officers, or as medical officers of institutions, or who are otherwise definitely concerned with defectives. The course will be based on the requirements of the syllabus for the University of London diploma in psychological medicine. The University will grant a certificate of attendance to those who have attended the whole course regularly, taking both theoretical and practical work. All communications with reference to the course should be addressed to Miss Evelyn Fox, c/o University Extension Department, University of London, Imperial Institute Road, S.W.7.

A course of four lectures on active and passive immunity will be given by Dr. R. A. O'Brien, C.B.E., Director of the Wellcome Physiological Research Laboratories, at University College Hospital Medical School on March 1st, 5th, 8th, and 12th, at 5 p.m. Professor A. E. Boycott, F.R.S., will preside at the first lecture.

Dr. Gustave Monod of Paris and Vichy will give a course of three lectures on hygiene at the Middlesex Hospital Medical School on March 2nd, 3rd, and 4th, at 5.30 p.m. At the first lecture the chair will be taken by Sir Arthur Newsholme, K.C.B. Admission to the lecture is free without ticket.

UNIVERSITY OF BRISTOL.

The following candidates have been approved at the examinations indicated:

FINAL M.B., B.Ch.B. (Part II).—*†C. B. Perry, G. W. R. Bishop, B. V. Cooke, F. S. Dymond, †E. R. Gedyne, A. P. Gorham, T. P. Lalonde, G. M. Minifie, L. B. Phillips, A. S. Prowse. (In Group II only): G. E. Feneley, Cecily France-Hayhurst. Part I.—J. C. Batt, Winifred P. Brinckman, A. M. Critchley, †T. F. Hewer, R. Jackson, J. E. Martin, J. R. E. Sansom, M. Srivasthi, †Dorothy M. H. Tripp, E. R. Wide.

Ch.M. (Gynaecology).—H. L. Shepherd.

* With second-class honours. † Distinction in obstetrics.
‡ Distinction in pathology, forensic medicine, and toxicology.
§ Distinction in materia medica, pharmacy, pharmacology, and therapeutics.

UNIVERSITY OF ABERDEEN.

Dr. JOHN CRUICKSHANK, Reader in Bacteriology and McRobert Lecturer in Pathology, has been appointed to the new chair of bacteriology in the University.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

An ordinary Council meeting was held on February 11th, when the President, Sir John Bland-Sutton, Bt., was in the chair.

Election to Council.

Letters were read from Sir Charles Ballance and Mr. J. Sherren resigning their seats on the Council, and these resignations were accepted with regret.

A meeting of the Fellows will be held at the College on Thursday, July 1st, at 2.30 p.m., for the election of four Fellows into the Council in the vacancies occasioned by the retirement in rotation of Mr. W. G. Spencer and Mr. E. W. Hey Groves and by the resignation of Sir Charles Ballance and Mr. James Sherren. Notice of the meeting will be given to the Fellows by advertisement and by circular on March 5th. The last day for the nomination of candidates will be March 15th. A voting paper will be sent on March 30th to every Fellow of the College (except women Fellows) whose address is registered at the College.

Hunterian Lectures.

Sir Arthur Keith's remaining three Hunterian lectures on "Fossil remains of ape and man and their bearing on the evolution of human races" will be given on February 22nd, 24th, and 26th.

Queen Victoria Jubilee Institute for Nurses.

Sir D'Arcy Power was reappointed to represent the College on the council of Queen Victoria's Jubilee Institute for Nurses for three years from March 1st next.

Diplomas of Fellowship were granted to Mr. Alan Cameron Maconie and Mr. Harold Burt-White, who have now complied with the regulations.

Diplomas of Membership were granted to 179 candidates, including 35 women, and diplomas in ophthalmic medicine and surgery were granted jointly with the Royal College of Physicians of London to 19 candidates. (The names of the diplomates were published in the report of the comitia of the Royal College of Physicians printed in our issue of February 6th, p. 266.)

Medical Notes in Parliament.

[FROM OUR PARLIAMENTARY CORRESPONDENT.]

THE House of Commons has again considered Supplementary Estimates this week, and has debated the new Treaty with Iraq. Orders laid on the table of both Houses include a number dealing with National Health Insurance and two concerning the General Nursing Council for England and Wales—one amending the rule relating to reciprocal registration and the other including a syllabus of subjects for examination for the certificate of general nursing. The Public Health and Housing Group of the Conservative party in the House of Commons met on February 16th and considered its operations for the session.

The Harnett Case.

In the House of Commons on February 15th, in Committee of Supply on a Supplementary Estimate for £26,660 for the salaries and expenses of the Board of Control (Lunacy and Mental Deficiency), England, and for grants in respect of maintenance for certain ex-service mental patients, and of certain damages and costs in a legal action.

Mr. Pethick-Lawrence called attention to the sum of £2,800 which appeared in the estimate in respect of the case of Harnett v. Bond. In this case, he said, the plaintiff, Mr. W. S. Harnett, brought an action against Dr. Bond, a Commissioner of the Board of Control, and another, on the ground of alleged wrongful imprisonment as a lunatic. He was released, according to the statement of the medical officer of the asylum, on twenty-eight days' leave. He found that his brother was in charge of his property, and went to the Board of Control to have the matter investigated. While he was there he interviewed a member of the Board, Dr. Bond, who detained him, and sent him back to the asylum, where he remained in custody for eight years. The jury awarded £25,000 damages against Dr. Bond and £5,000 against the medical officer of the asylum. On appeal, the Court of Appeal ordered a new trial as between the plaintiff and Dr. Bond. The plaintiff appealed against this judgement to the House of Lords, who dismissed the appeal. At this stage the Board of Control offered a sum of £250 as damages and £2,500 in respect of plaintiff's costs. After negotiations this offer was accepted. The case was a serious one, as this unfortunate man had not merely suffered eight years' detention as a lunatic, when he was sane, but he had also spent a sum of over £25,000 to obtain his rights. The taxpayer (who had had to pay the sum of £3,900 or £4,000 already) was now called upon to pay a further sum of £2,800.

Sir Kingsley Wood (Parliamentary Secretary to the Ministry of Health), in reply, said he thought that Mr. Pethick-Lawrence had been wholly misinstructed as to the facts of the case. He (Sir Kingsley Wood) intended to be very guarded in his reply, as he understood that Mr. Harnett had brought another action in the King's Bench Division against the doctor who gave the first certificate of his insanity.

Mr. Short asked the chairman (Mr. Hope) if it was right for the Committee to discuss the matter, seeing that it was again to be brought into court. He suggested that the vote should be withdrawn pending the final decision of the case.

Sir Douglas Hogg (Attorney-General) said it was possible to discuss the vote, which was necessary to carry out the arrangement come to in the first action, without touching on the issue in the forthcoming case.

The Chairman said that in the circumstances it would be better to withdraw the vote until later to allow him to consider the situation. He would not like to rule on the matter right off in case it might be taken as a precedent.

The vote was postponed accordingly.

Small-pox.

Answering Mr. Lansbury, Mr. Chamberlain said that from January 1st, 1925, to February 6th, 1926, 1,966 cases of small-pox had been notified in the county of Durham. In two instances small-pox had been entered on a death certificate as one of the causes of death. Medical officers of the Ministry of Health had paid numerous visits to advise and assist the local authorities and their officers. Reports of these medical officers indicated that the outbreak might be attributed to the spread of the disease from other infected areas, and that the present prevalence was in large measure due to the neglect of vaccination and in some districts to lack of adequate hospital accommodation. He did not think that the districts which were worst affected were those where men had been most impoverished, and he could not say what percentage of cases had been vaccinated. It would be difficult to draw any safe deduction from the figures in his possession, but they did not bear out the suggestion that the cessation of poor relief in a union was the cause of special prevalence of disease in that union, seeing that prevalence was less than in an adjoining union.

Mr. Chamberlain gave statistics showing that in the week ended January 24th, 1925, one case of small-pox was notified in county Durham, 11 cases in the week ended June 27th, 12 cases in the week ended September 26th, and 104 cases in the week ended December 26th. In 1926 the figures were: weeks ended January 2nd, 98 cases; January 9th, 138; January 16th, 139; January 23rd, 177; January 30th, 182; and February 6th, 213 cases. The areas where the disease was most prevalent were: Gateshead C.B., Blaydon U.D., Chester-le-Street U.D., Whickham U.D., South Shields C.B., Auckland R.D., Chester-le-Street R.D., Easington R.D., Houghton-le-Spring R.D., Lanchester R.D., Sunderland R.D., and Spennymoor U.D.

Mr. Davidson, Financial Secretary of the Admiralty, told Mr. Bromfield that restrictions on leave for naval officers and men in districts where small-pox was prevalent were necessary in view of the fact that, although every reasonable precaution was taken to ensure the protection of every individual in the navy against this disease by vaccination, there still must be a certain proportion unprotected, either by oversight or on the grounds of conscientious objection, to which must be added recent entrants who had not yet undergone protection by vaccination. In addition, dockyard employees were not under the same control as naval personnel as regards vaccination, and consequently a large proportion of them were non-immune, and as naval personnel and these employees were intimately associated infection might be carried either by a person in the early stages of small-pox or by the clothing of one who had been recently in contact with a case. No precaution should be neglected to prevent a case of small-pox occurring in one of His Majesty's ships or establishments, as, apart from the menace to health, great expense was incurred in isolation and destruction of clothing, bedding, etc. In addition, there was the inconvenience and expense of keeping all contacts of a case in isolation and under observation for fourteen days.

Sir Kingsley Wood, replying, on February 15th, to Sir William Davison, stated that the number of cases of small-pox in England and Wales had increased from 311 in 1919 to approximately 5,300 in 1925. The Minister of Health had no information as to the number of persons not protected by vaccination, but there could be little doubt that it had been steadily increasing since the war, although it was generally found that considerable numbers of persons presented themselves for vaccination when any serious outbreak of small-pox took place. The Minister had no information as to the number of infant children living to-day who were unvaccinated. In 1923, the last year for which complete information relating to the vaccinations of infants was at present available, 758,404 births were registered in England and Wales. Of these, 395,553 had not been vaccinated by January 31st, 1925. The percentage of vaccinations to births in 1923 was 47.8; and the corresponding percentage for 1905 was 75.8.

Sir William Davison asked whether the Ministry of Health would issue a leaflet urging upon the public the desirability of protecting themselves against small-pox by vaccination. Sir Kingsley Wood said he would put this suggestion before the Minister. Sir Henry Craik asked whether the Minister did not consider that the time had come to take legislative steps to protect the people. No answer was returned.

Encephalitis Lethargica.

Sir Kingsley Wood informed Mr. Ammon that the departments concerned were considering the best means of providing for such cases as that of the young man charged with theft at Lambeth on January 5th, who was found to be suffering from the after-effects of encephalitis lethargica. The arrangements made by the Metropolitan Asylums Board for institutional treatment of children suffering from mental after-effects of this disease provided for the ordinary hospital accommodation of the patients and for all necessary treatment and medical care. The Home Secretary told Mr. Ammon that at places of detention to which young persons under 16 were remanded medical attendance was usually afforded by a doctor in general practice, but where mental trouble was suspected the case might be referred to a school medical officer or other specially qualified doctor. Offenders over 16 were remanded to prisons where the medical officers were experienced general physicians and surgeons of good qualifications, with special

It is announced that under the auspices of the Health Organization of the League of Nations special laboratory courses on malaria will be arranged for medical practitioners in London, Paris, and Hamburg during next summer. Dr. Andrew Balfour will hold a theoretical and laboratory course in London from June 21st to July 24th, and Professor Brumpt and Professor Nocht will arrange similar courses in Paris and Hamburg respectively. Field work, lasting several months, in such infected countries as Spain, Italy, Corsica, Jugo-Slavia, and, possibly, Palestine, will follow the theoretical part. Further information may be obtained from the Health Section of the Secretariat of the League of Nations at Geneva.