Volume of Fluid.

This paper advises the administration of very large quantities of intravenous fluid, much larger than has been advocated elsewhere, except in the treatment of cholera. In neither case, nor in other less severe cases, has there been any untoward sign of cardiac embarrassment or dilatation, or of general or pulmonary oedema, although the tissues visibly filled out during the infusions. The absence of such signs may seem remarkable in Case ii, where 9¼ pints (7 intravenously) were given in eighteen hours and only a few ounces of urine were secreted in twenty-four hours. The dehydrated tissues must be able to absorb such quantities without any surfeit of fluid. It is impossible to state dogmatically the ideal amount of fluid to give, as this must vary in every case with the body weight and degree of dehydration. The following theoretical considerations may be of interest.

If we knew the weight of the patient a few days previously and were able to weigh the patient when first seen in coma, some idea of the water loss could be obtained. This was impossible in the above cases. But recently another patient, not completely unconscious, was weighed on admission to hospital and again twenty-four hours later after treatment with insulin and fluid. The patient gained 12 lb. in weight without any oedema—a gain in weight which did not fall on succeeding days. In that twenty-four hours she received only 3 pints intravenously, but abundance of fluids (not measured) by mouth, and only 60 grams of carbohydrate as food. This 12 lb. is equal to 16 per cent. of her body weight, and is about 10 pints of water. It may be taken as her amount of fluid loss, and she was not by any means an extreme case of dehydration, as the eye tension was only slightly reduced. In some cases the percentage loss of water and the total loss must be much greater. When we consider that the body of a man of average weight contains over 40 litres of water, there is no doubt that over 4 litres, and probably 6 or 8 or more, must be lost in extreme dehydration (7 to 14 pints). It is not surprising, therefore, that in Case ii, the most extreme, the patient showed no evidence of excessive administration of fluid when 9¼ pints had been given. Judging from the relatively poor condition of the pulse after 7 pints had been given, and its immediate improvement after only one pint of gum (the eighth), it seems probable that most of the intravenous fluid leaves the circulation for the tissues.

It is interesting to note the quantity of intravenous hypertonic saline given in the treatment of cholera. Rogers* advocates 3 to 6 pints of 1.2 per cent. saline given at the rate of 4 oz. a minute—that is, 1 pint in five minutes (I have never given it so quickly in diabetic coma). Cox of Shanghai advises continuous intravenous isotonic saline for *several* hours, until collapse is overcome, at the rate of 2 oz. per minute. That is, 1 pint in ten minutes or 6 pints in the first hour—very comparable to the amounts I have given, but far exceeding my dosage when carried on for several hours. The conditions, however, are different, for the loss of fluid will continue in cholera while the diarrhoea lasts, whereas the loss in diabetes gives way to oliguria or anuria.

From the practical point of view, we may be guided by the following clinical considerations. Enough intravenous saline should be given as soon as possible to fill visibly the shrunken tissues and re-establish the fullness and strength of the pulse. This may require 3 to 5 or more pints of fluid, and I consider it wise to finish the infusion with a pint of gum acacia, a fluid which remains in the circulation, while much of the saline rapidly leaves the blood and enters the tissues. It is desirable on theoretical grounds to commence with hypertonic saline (1.2 to 1.8 per cent.), but I have no proof that this makes any practical difference. After the intravenous treatment, it would seem advisable to give continuous subcutaneous (or rectal) saline, unless this is remaining localized and is not being absorbed into the general circulation, an indication that the body is sufficiently supplied with fluid. If the pulse volume relapses, more intravenous saline and gum solution (1/2 to 1 pint) should be given.

* See Manson's *Tropical Diseases*, ninth edition, p. 374.

The complete recovery of the eye tension is a sign that sufficient fluid has been given, but it is noticeable that the eye tension (and the secretion of urine) is slow of recovery, even when dehydration of the rest of the tissues has been overcome. A series of estimations of the haemoglobin percentage of the blood might indicate when sufficient fluid had been given, but is open to fallacies. The heart should be watched for signs of dilatation, and the ankles and lungs for oedema. I have not observed such danger signals occur, and think the risk is extremely small. In any case this risk must be taken if these moribund patients are to have any chance of recovery.

It may be that the ketone poisons *per se* are an important factor in producing the circulatory collapse, but there is no proof of this. I have, at any rate, observed several fatal cases in past years in which the ketonuria and ketonaemia has been greatly reduced by insulin without recovery of the circulation; these patients died, in my opinion, because I failed to supply the necessary large quantities of fluid.

I do not propose here to discuss the dosage of insulin, the necessity of warmth, and treatment with cardiac stimulants, although I think it important in every collapsed case to give a few minims of adrenaline in the first infusion. This has a remarkable, if temporary, effect in stimulating the circulation. Nor shall I discuss the advisability of giving sodium bicarbonate to replace the depleted alkali reserve and abolish acidosis. It may be noted, however, in the latter respect, that the hypertonic saline can very quickly remove the main symptoms of acidosis—the air hunger. In the last patient I treated, a litre of hypertonic saline completely abolished the air hunger in half an hour, before the infusion was finished or the pulse had recovered satisfactorily.

SUMMARY.

Attention is drawn to dehydration as the immediate cause of death from circulatory failure of desperate cases of diabetic coma. They die, as do cholera patients, from depletion of tissue and blood fluids, and often in the anuric state. The condition is recognized clinically by a feeble, empty pulse, shrunken tissues, low eye tension, and oliguria or anuria. In addition to insulin they require immediately large quantities of fluid, preferably intravenous. A treatment with hypertonic saline and gum acacia solution is described.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

BILIARY CIRRHOSIS IN AN ELDERLY WOMAN.

BILIARY cirrhosis of the liver is said to be commoner in young adults of the male sex. The following case, therefore, occurring in an elderly woman, appears to be worthy of record.

About 11.30 a.m. on January 19th I was called to see Mrs. X, aged 67, who complained of severe pain in the pit of the stomach. The onset was sudden, six hours previously, when she vomited, on one occasion, some bile-stained fluid. She was pale and sallow, but not markedly emaciated. She looked ill, toxic, and exhausted, with cold clammy skin, subnormal temperature, and rapid pulse; the tongue was dry and covered with a brown fur. There was repeated retching, with gaseous eructations. The abdomen was flaccid and not distended; there was epigastric tenderness, the liver was slightly enlarged, and on percussion the lower border was found to be one fingerbreadth below the right costal margin. No other abnormality was found in the abdomen or chest, apart from an occasional rale at the base of the left lung. No urine or stools were available for examination.

From 11 p.m. (her relatives stated) until 5 a.m. the following morning she repeatedly vomited black, tarry material, over one pint in all, and died suddenly at 7 a.m.

Previously, she had had rheumatic fever in childhood, and, during the last few years, frequent attacks of bronchitis. She had had attacks of diarrhoea, off and on, for the last two or three years, and had suffered from this continuously for the last three months. She always had a yellowish complexion, but had been strictly temperate in her habits.

At the necropsy all the abdominal contents, particularly the stomach and greater omentum, were tinged with bile, and there

was about one pint of foul-smelling brown fluid in the peritoneal cavity. The mucosa of the lower end of the oesophagus and of the stomach, duodenum, and upper two-thirds of the ileum was congested. Small varicose veins were visible at the lower end of the oesophagus, but none was seen to have been ruptured. Apart from catarrhal exudate covering the mucosa, the stomach was empty. The catarrhal changes were most intense in the duodenum and upper part of the ileum, where the bowel was plum-coloured and distended, and the mucosa was brick-red in colour and covered with coffee-coloured exudate; these appearances faded away towards the lower end of the ileum. The large bowel contained solid faeces throughout. No possible cause of intestinal obstruction was found.

The liver was slightly and uniformly enlarged; the surface was smooth and of greenish-yellow colour, with small congested areas; the organ was friable, the cut surface was uniformly yellow and of granular appearance, being divided into innumerable small islands by minute congested areas; no gall-stones were found in the gall-bladder or bile ducts. The spleen was slightly enlarged, firm, and congested. All the other viscera appeared normal, except the lungs, which showed some hypostasis at both bases. There was about half a pint of brownish-red fluid in each pleural sac.

The diagnosis was confirmed microscopically. A section of the liver showed that, although the lobular structure of the organ was recognizable, necrotic areas in which the liver cells were destroyed and separated from each other were numerous. A moderate amount of small, round-celled infiltration was seen in the portal areas, desquamation of epithelium had occurred in the bile ducts, but there was little evidence of fibroblastic reaction or of new formation of bile ducts.

Hodnet, Salop. J. NOËL BANKS, M.B., Ch.B.Ed.

STRANGULATED HERNIA IN AN INFANT.

I WAS recently called in to see a case of strangulated inguinal hernia of the right side in a male infant 5 weeks old. The clinical details are as follows.

On the previous evening the mother noticed a lump in the right groin about the size of a small egg, which appeared as the baby was crying. The infant refused food at 5 a.m. next day, was sick about 10.30, and had only passed a little blood from the rectum. It had not been particularly strong since birth. On examination a fairly freely movable swelling was apparent in the right inguinal region. This swelling was translucent, and it was by no means certain whether we were dealing with a hernia or a cyst. The fact that a neck could just be felt, which appeared to pass up into the abdomen, and the history, led us to advise operation.

At the operation a cystic swelling presented, with the testicle lying behind it; when this was opened it was found to contain a quantity of clear fluid, and at the upper end a knuckle of large gut. The neck of the sac had to be enlarged before it was possible to reduce the hernia. The infant is doing well.

I think that the extreme youth of the patient warrants the case being put on record.

T. W. MELHUISH, M.R.C.S., L.R.C.P.

Shanklin, Isle of Wight.

DEATH DURING SPINOCAIN ANAESTHESIA.

HAVING read articles lately on the subject of spinocain anaesthesia for abdominal operations, I think that the following case may prove to be of interest.

A man, aged 58, suffering from carcinoma of the caecum, was operated on some ten days ago, spinocain being injected at about the level of the eighth dorsal vertebra. The anaesthesia was supplemented with gas and oxygen. All went well for an hour and ten minutes, when the heart ceased beating and the respiration entirely stopped. With massage of the heart through the abdominal wound and intracardiac injection of adrenaline the heart resumed its function, after fifteen minutes, during which time not a single beat had been felt. Oxygen was administered through a laryngotomy tube; the operation was proceeded with and completed. The heart continued beating for three and a half hours after it had resumed its function, oxygen being administered, with CO_2, and artificial respiration being kept up with relays of assistants until death.

A remarkable feature was that rigor mortis had set in in the neck fully two hours before the heart finally stopped. The spinocain had been injected with the patient lying on his left side, the operating table being level; after the injection the patient's head was lowered, and kept in that position during the progress of the operation.

Victoria, British Columbia. A. B. HUDSON.

Reports of Societies.

AMPUTATIONS AND THEIR RELATION TO THE ARTIFICIAL LIMB.

AT a meeting of the Section of Surgery of the Royal Society of Medicine, on April 2nd, Sir HOLBURT WARING presiding, a discussion was held on amputations and their relation to the artificial limb.

Mr. C. MAX PAGE, in opening, said that the surgery of amputations, although it represented the oldest branch of the subject, remained somewhat academical in its teaching until the war. The large number of amputations which then took place in this and other belligerent countries produced new ideas and methods. The early conclusions which traversed pre-war teaching had been made clear by Mr. Muirhead Little, who had produced a most valuable book of reference on the subject. Experience of the last ten years had further crystallized views on certain practical points, and the speaker's role in that discussion was to indicate the attitude of the operating surgeon to the problem. The general principles which governed the technique of any final amputation in either extremity might be defined as those which gave the stump the following characters: (1) approximately conical shape, except when the amputation was very close to the trunk; (2) ability to provide a lever of sufficient length for the attachment of an artificial limb suited to the level of the amputation; (3) closely covered by healthy, well-nourished skin or scar, both of which should be mobile on the deeper structures; (4) with no part tender on pressure or abnormally sensitive. For the below-knee amputation everyone was agreed that the ideal length of tibia to leave, circumstances permitting, was 7 inches, but a stump with as little as 4 inches of tibia was quite capable of controlling an artificial limb. If more than 7 inches of tibia was left it would be covered by skin of poor nutrition, which would almost inevitably break down and cause inadequacy of support for prosthesis. In leaving 4 or 5 inches of tibia it was worth while to remove the fibula entirely, thus diminishing the risk of pressure sores. In above-knee amputations the length which appeared to give the most satisfactory functional stump was one containing 10 to 12 inches of femur. One was tempted to spare as much of the femur as possible, but a rather long thigh stump often proved unsatisfactory. He was interested to see that in America and Germany the Stokes-Gritti amputation, which left something like 14 inches of femur, was very popular. It aimed at producing an end-bearing stump, but in the experience of limb-fitting centres in England these end-bearing stumps in the thigh had proved a failure.

The speaker then passed to some points in technique in an individual amputation which might affect the individual stump. The flaps should be approximately circular in shape in order to interfere with nutrition as little as possible; their total length should be little greater than the diameter of the limb at the level of section, and they should be of skin only. It was of interest to note that many American surgeons advocated the suture of muscle or tendon at the end of the bone or across it. The nearer the flap approached to a circular or elliptical shape the better the nutrition was maintained. With regard to the inclusion of muscle in the flaps, the importance lay in cutting a wedge of muscle at the base of the flap in order to maintain nutrition, and not for any other purpose. In the treatment of bone, to avoid spur formation his own practice was to divide the periosteum about half an inch above the level of the saw cut, so that this passed through bone and not through periosteum at all. Attempts to cover the end of the bone with a graft in his experience led to failure and necessitated a re-amputation. He held the strong opinion that osteoplastic treatment of the cut end of the bone was not desirable. In the treatment of the nerves at the end of the stump it had been customary to identify as many of the large nerves as possible, pull them down, crush them, ligature them, and cut them off. The rather gross handling of large nerve trunks was overdone, and many of the patients had post-operative pain, which might be the basis of permanent subjective pain. The nerves

because there was not a sufficient supply of new houses. No measure—not even the present bill—would be any good unless it helped to provide new houses in which to rehouse persons removed from the slum areas. One very material reason for delay in clearing slum areas was the Rent Restriction Act, which was not dealt with in this bill. Medical officers of health would welcome certain parts of the bill. In Clause 17 there was a very valuable power, which enabled part of a house to be closed without closing the house altogether. There were also valuable provisions in the improvement clause, which was really the only novelty in the bill. The provision for the aged should be extended. The method of subsidy was a valuable feature. It attacked overcrowding, which was really the greatest difficulty of all.

The bill was read a second time.

Position of Pharmacists in Poor Law Hospitals.

On the motion for the adjournment of the House of Commons, on March 31st, Captain GUNSTON called attention to the position of pharmacists in Poor Law hospitals under the Draft Poor Law Order published by the Ministry of Health, and now called the Public Assistance Order, 1930. He said that pharmacists were very much concerned about the Order, because they felt that the status of members of their profession employed in Poor Law hospitals would be seriously jeopardized. He asked that the Ministry should allow a local authority to make the pharmacist a principal officer if it wanted to do so. They did not ask for more control, but simply that these matters should be left in the hands of the local authorities.

Miss LAWRENCE said that if that were all that was asked she could answer "Yes." This was not a new Order. It was an old Order, reissued and reprinted—nothing more. There was no modification of substance. The only modification was the verbal one necessitated by the change in the names of the new authorities. If local authorities desired that a pharmacist should be a chief officer they could recommend the matter to the Minister and discuss it with him, and even appoint him as chief officer before the Minister examined the question. The assurance was given to the local authorities by the previous Government that any amendment or modification with regard to superior officers should not be made until after consultation with the authorities. If any amendment was desired it could be made subject to consultation with the local authorities. The Ministry had changed nothing. They had not made it impossible for these people to be appointed. In these matters, as in every other, they had left the position as it was, for consultation with the new authorities.

Tuberculin-tested Cows and Agricultural Shows.—Mr. GREENWOOD made a statement to Mr. Ramsbotham, on March 27th, regarding the order prohibiting the exhibition at shows of animals from tuberculin-tested herds. He said some of the bodies organizing agricultural shows were now prepared to arrange for the segregation of animals belonging to licensed tuberculin-tested herds, and he had promised to see their representatives with a view to considering the withdrawal of the prohibition in shows where effective provision was made for this purpose.

Psittacosis.—Mr. GREENWOOD told Mr. White, on April 3rd, that the Ministry of Health had received information of twenty cases of illness which commenced last month and in which the patients had been associated with parrots. In the present state of knowledge it was impossible to say definitely how many of these persons were suffering from psittacosis. This was not a notifiable disease.

Vaccination of Small-pox Suspects.—In a reply, on April 3rd, to Mr. Groves, Mr. GREENWOOD said he knew that doctors in the service of the Metropolitan Asylums Board vaccinated children sent to the shelters as suspected cases of small-pox, and that this was done without reference to the wishes of the parents or the fact that many of the children had been legally exempted from vaccination. The vaccination was solely in the interests of the children, who whilst under observation were exposed to small-pox infection at the shelters, in order that they might be protected against an attack of that disease if they had not already contracted it. It would not be desirable, in view of the risks involved, to make any exception to this practice. He had no authority to issue instructions that no child taken to the hospitals or shelters of local authorities should be vaccinated without the consent of its parents.

Silicosis.—Mr. SHORT, on April 1st, told Mr. Millar that the Home Secretary was not satisfied, on the evidence at present before him, that there was any sandstone quarry to which the Silicosis Order applied, in Scotland or elsewhere, in which there was no risk of silicosis. The medical inquiry into silicosis among sandstone workers, arranged for by the Home Office and Mines Department in 1928, extended to Scotland, and disclosed cases of silicosis in every area in which examinations were made, and showed that quarrying was among the dangerous occupations. Fuller information would be obtained from the medical examinations now being made at quarries by the medical board set up under the scheme. The Home Secretary intended, when these were completed, to review the position.

London Lock Hospital.—In a reply to Mr. Ernest Brown, on April 3rd, Mr. GREENWOOD said the governing body of the Lock Hospital had given effect to a large number of the recommendations contained in the papers presented to Parliament last July. Further improvements were in contemplation. The interests of the hospital would not be served by detailing at present the reforms effected. The board of management of the hospital included six women.

Health of the Mercantile Marine.—On April 1st Mr. GRAHAM told Mr. T. Lewis that the committee set up to consider and advise on questions affecting the health of the mercantile marine had in hand a detailed investigation into the question of how far and in what way the statistics relating to the mortality of seamen could be improved. The committee would inquire into the deaths reported month by month, from October last probably until September next. No report could therefore be expected for some months. Work on the hygiene of crew spaces on board ship was well advanced.

Sickness Certificates under the National Health Insurance Act.—On March 31st Miss LAWRENCE told Sir Kingsley Wood that the issue of sickness certificates under the National Health Insurance Act had been under discussion with representatives of those concerned for a considerable time. The draft of a new regulation with respect to this issue would be published at a very early date.

The Services.

THE GILBERT BLANE MEDAL.

THE Gilbert Blane medal has been awarded this year to Surgeon Lieutenant Commander J. F. H. Gaussen, R.N. The medal, which was founded in memory of the late Sir Gilbert Blane, is awarded annually to the medical officer who obtains the highest aggregate marks at the examination for promotion to the rank of surgeon lieutenant commander.

DEATHS IN THE SERVICES.

Lieut.-Colonel Eric Harding Sharman, Madras Medical Service (ret.), died suddenly in a nursing home at Bournemouth on March 5th, aged 64. He was born on July 21st, 1865, the son of the late Mr. Eric Rudd Sharman of Liverpool, and was educated at Westminster Hospital. After taking the M.R.C.S. and L.R.C.P.Lond., in 1890, he filled the posts of senior house-physician, house-surgeon, and clinical assistant in the skin and throat departments at Westminster Hospital, and of house-surgeon to the Hospital for Sick Children in Great Ormond Street, London. He entered the I.M.S. as surgeon lieutenant on July 29th, 1893, became lieutenant-colonel on January 30th, 1913, and retired on August 1st, 1913. In 1904 he took the diploma in tropical medicine of Liverpool University. He served in the China war of 1900, receiving the medal, and rejoined for service in the war of 1914–18.

Universities and Colleges.

UNIVERSITY OF BRISTOL.

THE following candidates have been approved at the examination indicated:

M.D.—J. F. O. Bodman, T. F. R. Hewer.

UNIVERSITY OF GLASGOW.

THE following candidates have been approved at the examination indicated:

M.B., B.Ch.—Isabel M. Adam, J. M. Alexander, *G. H. Bell, D. C. Brodie, G. H. Campbell, L. Charmatz, T. Crawford, A. N. Currie, D. W. Dewar, A. Duff, C. N. Gibb, A. Gibson, J. S. Gillies, W. Gunn, †J. F. Heggie, A. S. Henderson, S. T. Henderson, D. Jacobs, M. K. Johnston, Helen M. Keith, ‡R. Kirk, W. R. Logan, G. M'Dougall, J. A. M'Ewen, D. M'Ghee, N. S. R. MacGregor, D. A. M'Intyre, J. B. L. M'Kendrick, D. Macrae, W. R. Martyn, A. R. Miller, Mabel E. Mitchell, Mary Nicolson, J. Padkin, F. B. Proksch, Hanna Rizkalla, J. R. Robertson, D. Ross, Agnes A. S. Russell, J. G. Scott, A. Seton, A. M. Spence, Mary F. Tanner, D. W. Walker, A. B. Wallace, A. Young, T. M. Young.

* Distinction in surgery and midwifery.
† Distinction in medicine and midwifery.
‡ Distinction in midwifery.

NATIONAL UNIVERSITY OF IRELAND.

UNIVERSITY COLLEGE, DUBLIN.

THE following candidates have been approved at the examination indicated:

D.P.H.—*Part I:* *P. J. Deery, *P. Keane, *M. M. J. Maughan, †J. J. Ryan, †G. F. Cullen, †C. Bastible, J. Dunne, M. Kirby, Mary F. Moloney, P. J. Nagle, Margaret O'Farrell, J. O'Gorman, J. O'Neill, Margaret M. Partridge. *Part II:* M. Peppard.

* First-class honours.
† Second-class honours.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND.

AT the monthly business meeting of the College, held on April 4th, the following candidates nominated on January 3rd were duly elected Fellows: David Gray, Ninian M'Intire Falkiner, Edward Thomas Freeman, Victor Ormsby M'Cormick.

The following, having passed the Final Conjoint Examination held in March, were duly admitted to the Licences in Medicine and Midwifery: J. H. de Villiers, D. Dorgan, V. J. Fielding, T. S. Harbison, J. E. Lewis, J. Lewis, Doris F. Weir.

Medical News.

ON Friday, April 18th, at 3 p.m., the Glasgow and West of Scotland Branch of the British Medical Association will give a reception, in the Students' Union of the University of Glasgow, to the students graduating in medicine on the following day.

THE house and library of the Royal Society of Medicine will be closed from Thursday, April 17th, to Tuesday, April 22nd, both days inclusive.

MR. SOMERVILLE HASTINGS, Dr. Salter, Dr. Ethel Bentham, about forty medical men who are not M.P.s, and two dentists met at the House of Commons on April 7th and adopted a constitution for a proposed National Medical Service Association. The constitution states that the association is to be independent of any political party. Membership is to be open to all registered medical men and women and dentists and to registered medical and dental students, and to such others as are in sympathy with its objects, and are invited to join by the executive committee. The association is to "advocate and make clear to the medical profession and to the public the advantages of a National Medical Service. For this purpose it shall from time to time hold public meetings, publish and circulate literature, and otherwise promulgate its cause. The association shall take all necessary steps to promote and secure legislation giving effect to its objects." A footnote to this constitution runs: "A National Medical Service should include the establishment of a medical service available to all members of the community, and providing every necessary form of medical, surgical, obstetrical, dental, and preventive treatment, co-ordinated as one service under the Ministry of Health. This would entail the provision of all necessary institutional treatment, consultant and specialist services, together with all known means for the prevention, diagnosis, and treatment of disease. The attainment of these objects will involve the formulation of a scheme or schemes by which the existing national health services and other State, municipal, and public services can be transformed, extended, and evolved into a comprehensive National Medical Service."

A THREE months' course of lectures and demonstrations in clinical practice and in hospital administration for the diploma in public health commenced on April 9th at the North-Eastern Hospital, St. Ann's Road, Tottenham, N.15. They will be continued on Mondays and Wednesdays, at 4.45 p.m., and alternate Saturdays at 11 a.m. The fee for the course, which complies with the revised regulations of the General Medical Council, is £4 4s. A course under the old regulations may be taken for £3 3s.

OWING to the Easter vacation no special courses have been arranged to be held under the auspices of the Fellowship of Medicine until April 28th, on which date three courses begin. These are an intensive clinical course in ear, nose, and throat diseases at the Central London Throat, Nose, and Ear Hospital, for four weeks; a four weeks' comprehensive course continuing until May 30th at the Maudsley Hospital, consisting of a series of lectures and demonstrations dealing with psychological medicine from various aspects; and an afternoon course lasting for two weeks at the Infants Hospital, under the direction of Dr. Eric Pritchard, especially suitable for those interested in infant welfare work. Several courses will take place in May, the subjects including: dermatology, at St. John's Hospital; ante-natal treatment, at the Royal Free Hospital; diseases of the chest, at the Victoria Park Hospital; diseases of children, at the Hospital for Sick Children; and medicine, surgery, and the specialties, at the Queen Mary's Hospital. From May 13th to July 4th there will be a course for the M.R.C.P. examination. Detailed syllabuses of all courses can be obtained from the secretary of the Fellowship, 1, Wimpole Street, W.1.

THE tenth of the series of congresses known as the Journées Médicales de Bruxelles will be held from June 28th to July 2nd, under the presidency of Professor Jules Bordet, and in connexion with the celebration of the centenary of Belgian independence. In addition to the usual meetings and receptions in Brussels, a visit will be paid to Liège. The French and Belgian railways will allow a reduction of 35 per cent. on the ordinary charges. Further information may be obtained from the general secretary, Dr. R. Beckers, 62, rue Froissart, Brussels.

THE eighth International Congress of Dermatology and Syphilis will be held at Copenhagen from August 5th to 9th, when the subjects for discussion will be the etiology and pathogenesis of eczema, immunity, reinfection, and superinfection in syphilis, and cutaneous tuberculosis and its treatment. Further information can be obtained from the general secretary, Dr. Svend Lomholt, Copenhagen.

THE annual congress of the German Society for Investigation of the Circulation will be held at Dresden on June 11th and 12th. Further information can be obtained from Professor Bruno Kisch, Köln-Lindenthal, Lindenberg.

THE report of the Joint Tuberculosis Council for 1928 and 1929 gives an outline of the activities of that body since the issue of the last report in January, 1928. Special mention is made of a memorandum on disinfection in tuberculosis circulated by the Council, and the statistical research on the fate of young children in tuberculous households, which was undertaken by Dr. Lissant Cox and the Lancashire group of tuberculosis officers. A recent memorandum by the Council on the subject of notification was circulated at the beginning of this year, and was mentioned in our columns on March 1st (p. 427). The report also refers to the steps taken by the Council to improve the tuberculosis service, to promote post-graduate study, and to ascertain the position with regard to the employment of tuberculous patients. The Joint Council includes representatives of medical organizations and Government departments; the British Medical Association is represented by Dr. C. O. Hawthorne and Dr. Arnold Lyndon.

A NEW catalogue of medical books has been issued by the Oxford University Press, including details of nearly 400 current works on medicine, surgery, and allied subjects, duly classified. We are informed that specimen copies of all these books may be inspected in the library at the London office of the Press, Amen House, Warwick Square, E.C.4.

THE Walton Hospital Training School for Nurses, Liverpool, has issued an illustrated booklet giving particulars of the training it provides for probationers and certificated nurses who are studying for the final examinations of the General Nursing Council and of the Central Midwives Board. Courses are also available for male nurses. The hospital, which is subject to inspection by the Ministry of Health and the General Nursing Council, has about 1,650 beds, and over 13,000 patients pass through the wards every year.

AT a meeting of the Chelsea Clinical Society, at the Hotel Rembrandt, Thurloe Place, S.W., on April 15th, at 8.30 p.m. Dr. R. A. Young and Mr. Philip Franklin will open a discussion on "Coughing." The meeting will be preceded by dinner at 7.30.

THE annual dinner of the Medical Superintendents' Society took place at the Holborn Restaurant on March 28th, with the president, Dr. E. W. G. Masterman, in the chair. Dr. Daly, in proposing the toast of "The Society," recalled some of the past history of the society, which was formed in 1887. Dr. Masterman, in reply, outlined the society's activities in the past, and pointed out that its name had been changed from Infirmary Medical Superintendents' Society so as to enlarge its membership, which now embraced medical superintendents of all public hospitals and voluntary hospitals, and whole-time medical officers in responsible charge of patients in public hospitals or institutions for the sick. Dr. Barrie Lambert, in reply to the toast of "The Guests," emphasized the enormous work the London County Council had undertaken, and showed the need for co-operation between the London County Council and the medical superintendents. Dr. J. J. Buchan, as a medical officer of health, stressed the need for co-operation between the curative and the preventive side of medicine.

AS an extension of the work of the St. John Ambulance Association, the first of three special rail coaches, designed to promote first-aid instruction among the 100,000 employees of the Canadian National Railways Company, has just been brought into use. The cars, which are miniature hospitals, including the latest emergency equipment and lecture theatres for first-aid demonstrations, will be used primarily in the more remote parts of Canada where the opportunities for the study of first aid under competent instructors are limited. Employees of the railway are encouraged to attend lectures on first aid in working hours, a corps of experts being retained for demonstration purposes. A special Canadian National Railway Council of the St. John Ambulance Association was established some years ago, and as a result of its activity 35,000 employees have obtained certificates of proficiency in first aid.

THE KING has granted authority to Dr. B. Spearman, Deputy Director of Sanitary Services, Zanzibar, to wear the Insignia of Class III of the Order of the Brilliant Star, conferred upon him by the Sultan of Zanzibar in recognition of valuable services rendered.

THE Union Castle Steamship Company has issued a series of folders giving particulars of a special summer tour to South Africa at reduced return fares, fortnightly holiday cruises from London to Antwerp, Rotterdam Hamburg, and back, and weekly sailings to Madeira and the Canary Islands. Further information may be had from the Union Castle Mail Steamship Company, Ltd., 3, Fenchurch Street, London, E.C.3.